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The Roles of the Edinburgh, Kelso, and Newcastle Dispensaries in Charitable Relief, 1776-1810

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Abstract

This thesis explores late eighteenth- and early nineteenth-century British charitable medical provision through a comparative study of the Edinburgh, Kelso, and Newcastle dispensaries. It is situated within historical scholarship concerned with institutional histories, charitable relief systems, and medical therapeutics. The research draws on a range of sources, including records which have not previously been studied such as dispensary patient case notes. It also contextualises dispensary provision by studying alternative sources for medical relief for the poor in surrounding districts, including poor relief systems, infirmaries, and other charitable bodies.

By adopting both statistical and narrative approaches this thesis demonstrates the variation in models of dispensary management and treatment and considers the impact on dispensary provision of local factors such as harvest failures, epidemics, and employment models. It considers the differences between the theoretical approaches of these dispensaries as presented in annual reports, newspapers, and promotional publications, and the practical realities of their provision. It also looks beyond the administrative models of the dispensaries to explore the employment, age, and gender of dispensary patients. The dispensary outpatient model of treatment often provided for a distinctly different demographic of society than other relief systems such as infirmaries and workhouses. This thesis, therefore, provides insight into sickness experiences which have previously been largely unexplored.

This research considers the practical application, as well as theoretical frameworks, of medical treatment during the late eighteenth and early nineteenth centuries. By giving priority to practice over theory this thesis provides insight into the medical treatments which were commonly adopted by practitioners. In doing so it uncovers the context of these treatments, not only which diagnoses they aimed to ameliorate, but the patients' symptoms and the identified outcomes of these treatments. This approach also enables analysis of the reception of these treatments by patients. It contributes to existing scholarship by considering ideas around patient agency and concepts of shame, particularly in relation to the diagnosis and treatment of genito-urinary complaints.

Lay Summary

Dispensaries were established in the late eighteenth century to provide free medicine and advice to the sick poor. They were not the only institutions to do this, infirmaries and other charitable bodies were set up to provide a similar function. There were distinct differences, however, between dispensaries and these other forms of relief. Infirmaries, unlike dispensaries, had rules which made it difficult for some to access their services. Dispensaries, by contrast, were commonly open to anyone who presented themselves for treatment. As a result, a wider range of people used dispensaries than these other charities. Dispensaries frequently admitted more women, more children, and more elderly individuals.

This study, by using sources such as patient case notes, provides insight into who these patients were, their occupations, their families, and their responses to the medical treatment which they were given. It shows which treatments they accepted willingly and which they did not. It also shows which medical conditions patients were ashamed to discuss and which they were not. By comparing three different dispensaries this study shows many similarities in the rules and systems of organisation which they adopted. It also uncovers significant differences based on local circumstances. The dispensary based in Kelso adapted to treating the ageing local population while another, in Newcastle, accommodated the needs of its industrialising surroundings. The third dispensary, in Edinburgh, was in a city filled with medical innovations and competition between charities and medical practitioners.

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Declaration of Authorship

I, Daisy Cunynghame, declare that this thesis has been composed solely by me, the work presented is my own, and it has not been submitted for any other degree or professional qualification.

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List of Figures

Abbreviations

DCA Dundee City Archive and Record Centre

ECA Edinburgh City Archives

HHH Hawick Heritage Hub

LHSA Lothian Health Services Archive

NLS National Library of Scotland

NRS National Records of Scotland

NUC Newcastle University Special Collections

RCPE Royal College of Physicians of Edinburgh Archives

TWA Tyne and Wear Archives

UDA University of Dundee Archives

UEC University of Edinburgh Centre for Research Collections

WL Wellcome Library

Introduction

> DISPENSARY, a kind of charitable institution of late years very prevalent in Britain… They are supported by voluntary subscriptions, have each one or more physicians and surgeons, whose business it is to attend at stated times, in order to prescribe for the poor; and, if necessary, to visit them at their own habitations… Many abuses have been found to exist in the management of these charities, which, in some cases, have been set on foot for the mere purpose of raising some young practitioner into notice; whilst the contributions thus drawn from the public, have lessened those before appropriated to the hospitals, almost to the entire ruin of the latter.[1]

This entry in a medical dictionary dating from 1807 clearly strays beyond a simple definition of the term 'dispensary' and into the personal opinions of its authors. Whether this text was written as the result of a personal grievance against particular dispensary founders is not made clear, but the fact that it was published in Edinburgh at a point in time when there was only one dispensary in that city suggests a connection between these words and that institution. Certainly one of the authors, James Kendrick, had a personal investment in the subject matter as he founded his own dispensary in Warrington, Cheshire, only three years after the publication of this text.[2]

The authors of this medical dictionary did not feel the need to provide descriptions of other medical institutions such as hospitals or infirmaries. Dispensaries, therefore, stand out as medical bodies which were viewed as contentious and in need of definition and, in this case, of condemnation as well. This description is also notably more strident in its wording than that contained in a similar work, the *London Medical Dictionary*, which was published two years later, in 1809.[3] That text made a greater attempt to balance the negative with the positive, stating that dispensaries are 'more advantageous than hospitals, as a greater number of patients are relieved at less expence [sic]; and less useful, as the diet and other circumstances cannot be properly attended to.'[4] Although the role of dispensaries in enabling young physicians to advance their careers is also mentioned here, the tone is

[1] Robert Morris and James Kendrick, *The Edinburgh Medical and Physical Dictionary, Volume One* (Edinburgh, 1807), n.p.
[2] R. Guest-Gornall, 'The Warrington Dispensary Library', *Medical History*, 11:3 (1967), p.286.
[3] Bartholomew Parr, *The London Medical Dictionary, Volume One* (London, 1809), p.568.
[4] Ibid.

significantly more measured, stating that while it enables a physician to 'display his importance' it is also a useful method for him to 'acquire practical knowledge'.[5]

In spite of their differences of opinion, the authors of these definitions shared the view that dispensaries had a significant impact on medical practice in the late eighteenth and early nineteenth centuries. Increased public interest in these institutions, demonstrated by their inclusion in such dictionaries, was in large part the result of a dispensary boom which began in Britain in the 1770s, for the later eighteenth century saw a marked growth in dispensary provision throughout Britain. Exact numbers given by historians vary, but as an indication Hilary Marland states that 38 dispensaries were in operation in Britain by 1800.[6] This thesis intends to address, through the study of three such institutions, the role of dispensaries in medical provision for the sick poor.

These institutions have largely been neglected in the historical scholarship, with the focus more often placed upon infirmaries and poor relief systems. However, the impact of dispensaries in the late eighteenth and early nineteenth centuries should not be underestimated and this thesis will demonstrate the integral role which they played for the patients who they treated. This type of institution meant a great deal to the people who turned to them for in-work medical aid. Their outpatient system of treatment, by allowing patients to maintain family structures and continue employment, provided for a different section of society to their infirmary and workhouse counterparts. This thesis, by both applying statistical analysis and exploring the narratives of individual patient cases, will uncover who dispensary patients were, their medical complaints, and the treatment which they received. It will interrogate the patient perspective in a period where the poor patient's voice is rarely recorded. By doing so, it will provide insights into the experience of illness for ordinary men and women.

This thesis will also consider how factors such as gender, age, and social class impacted on the diagnosis and treatment of dispensary patients. Some medical complaints, such as gout and rheumatism, were viewed by many eighteenth-century practitioners as both gendered and class based, the former being predominantly a disease of wealthy men,

[5] Ibid.
[6] Hilary Marland, 'The Changing Role of the Hospital, 1800-1900', in Deborah Brunton (ed.), *Medicine Transformed: Health Disease and Society in Europe, 1800-1930* (Manchester, 2004), p.35.

while the latter was more often identified amongst women and the poor.[7] This is exemplified in the case of Ann McNicol, who was admitted into the Edinburgh dispensary in the winter of 1785 with violent pains of the joints, particularly in the elbows and knees.[8] According to her case notes there was 'no room for doubt' that her condition was rheumatic.[9] McNicol, a 40-year-old married woman, was employed in spinning textiles and as a wet nurse.[10] Although the dispensary's notes detailed the difficulty of distinguishing between rheumatism and gout, in making the distinction in this instance it was 'suffic[ient] to observe, that [the] patient is a female & one of [the] lab[ouring] poor'.[11] Poverty and gender, therefore, could be the key diagnostic identifiers in cases of rheumatism rather than the medical symptoms of the patient.

In other cases, such as that of Jean Holbert, age could be the primary diagnostic signifier. Holbert was admitted into the Edinburgh dispensary, aged 10, in the winter of 1789.[12] Despite suspicions of the dispensary's medical staff that the case appeared to be venereal in nature Holbert was initially diagnosed as suffering from scrofula on the basis of the 'posit[ive] assert[ion] of [her] mother' that she had not had 'any expos[ure] to [venereal] infect[ion]'.[13] The dispensary physician who treated her believed that if the mother had 'known or even susp[ected] any thing of that kind [she] would have been ready to tell us'.[14] The patient's age, however, and the lack of venereal symptoms displayed by her mother, were not grounds for the dismissal of this possibility because, as the dispensary physician stated, he had previously met many young girls who had been infected by 'wretches', because of the 'prev[alence] among [the] vulg[ar]' of the notion that syphilis could be cured by transmitting it to another individual, usually a young virgin.[15] Indeed, the accuracy of his assessment was demonstrated by a single stark entry on a subsequent visit

[7] For contemporary discussions on rheumatism and gout see: Thomas Fowler, *Medical Reports of the Effects of Blood-Letting, Sudorifics, and Blistering, in the Cure of the Acute and Chronic Rheumatism* (London, 1795); John Latham, *On Rheumatism, and Gout; A Letter Addressed to Sir George Baker* (London, 1796).
[8] Ann McNicol, *Practical Observations in Medicine by Andrew Duncan*, 1785 (DEP/DUA/1/38), pp.108-122.
[9] Ibid., p.111.
[10] Ibid., p.108.
[11] Ibid., p.111.
[12] Jean Holbert, *Practical Observations in Medicine by Andrew Duncan*, 1789 (DEP/DUA/1/46), n.p.
[13] Ibid.
[14] Ibid.
[15] Ibid.

of the patient that 'Her mother has now discovered that she has been exposed to venereal contagion'.[16]

In this instance the age of Holbert, and the resulting need to rely on her mother's testimony regarding her condition, significantly delayed the successful identification of her complaint. As the examples of McNicol and Holbert make clear, the diagnosis and treatment of disease in the eighteenth century cannot be studied outside their social and economic contexts. The employment and familial structures of the patient were essential in determining the medical response which was adopted. In the context of the conditions which will be studied in detail in this project, including intestinal worms, indigestion, and urinary complaints, understanding both the patient's individual circumstances and their surrounding environments were viewed as key to the treatment process. They are also essential factors for the historian to consider when studying these conditions. This includes not only the personal circumstances of the individual patient, but also local conditions such as the range of charitable relief options which were available in the surrounding districts, the economic and employment models of the area in which the dispensary was based, and the periods of epidemic and famine which the community was subject to.

This is the first work to make a comparative study of medical practices across not just urban and rural environments but encompassing both Scotland and the north east of England. Adopting this approach ensures that this study is not restricted by regionalism. In the study of a single institution or geographical area it cannot be assumed that any factors identified are representative of broader trends or movements. By studying three dispensaries, and their surrounding communities, this thesis can assert the results of its findings with more assuredness than a single case study would allow. By comparing Edinburgh, Kelso, and Newcastle this enables the identification of dispensary models of operation, patient demographics, and approaches to treatment which were common across all three districts. It will also provide evidence of the distinctiveness of certain aspects of their medical provision and the specific local circumstances which caused them. Instances

[16] Ibid. For a more detailed discussion of the phenomenon of supposed cure by the infection of others, see Antony E. Simpson, 'Vulnerability and the Age of Female Consent: Legal Innovation and its Effect on Prosecutions for Rape in Eighteenth-Century London', in G. S. Rousseau and Roy Porter (eds), *Sexual Underworlds of the Enlightenment* (Manchester, 1987), pp.181-205.

which, taken in isolation, might not appear to be unusual, will be identified for their distinctive nature by comparison to those other cases.

Adopting the comparative history model at this regional level, rather than as a model for comparing nations as a whole, enables the contextualising of these institutions within their local environments. Furthermore, focusing upon individual dispensaries is essential when studying the late eighteenth and early nineteenth centuries as during this time there was a distinct lack of national guidelines and standardised approaches to medical practice and public health activities. By comparison to developments which took place during the mid to late nineteenth century, in this earlier period medical relief was extremely localised, based on the initiatives of individuals and local bodies. This is not to imply that the Edinburgh, Kelso, and Newcastle dispensaries existed in complete isolation. These institutions did not perform their activities independently either from each other or from other charitable bodies within their communities. They were interwoven in a mesh of connections which took a range of forms from literal contact between practitioners at the various institutions to the influences of their published works and their public activities on one another. However, while connections between the medical staff of individual dispensaries often resulted in similar frameworks and regulations being put in place, the way that each dispensary responded to particular needs of their surrounding districts, as this thesis will demonstrate, was often markedly distinctive.

Identifying the Practitioner, the Patient, and the Disease

This study serves as a significant addition to the existing historiography of late eighteenth-century medicine in several different ways. One of its contributions is to place the dispensary physician within discourses on the changing role of medical practitioners and the formalising and structuring of professional medicine which took place during this period. A focus on the professionalisation of medicine was brought particularly to the fore by a number of sociological studies carried out in the 1970s. A range of scholars, including the sociologists Noel and José Parry and Eliot Friedson, wrote on the process by which medicine became, what could be considered, a profession.[17] While no standard definition of what

[17] Noel Parry and José Parry, *The Rise of the Medical Profession* (London, 1976); Eliot Friedson, *Professional Dominance: The Social Structure of Medical Care* (New York, 1970).

comprised a profession was arrived at, factors such as monopoly of trade, intellectual cohesion, and legal supporting structures were often considered to be key.[18] Although by no means an approach followed by all historians, some, particularly notably Toby Gelfand, took professionalisation as the model for their work in studying medical developments in this period.[19]

This approach has had a range of critics, however, particularly since the mid-1980s. Seen as an attempt to apply principles only founded in the nineteenth and twentieth centuries, historians such as Margaret Pelling and Thomas Broman have emphasised, by contrast, the importance of studying the eighteenth century on its own terms.[20] Broman has argued for the application of what he sees as more contemporary eighteenth-century identifiers of professional status, including gentility, patronage, and social standing.[21] Pelling has further demonstrated, in her writing on the Royal College of Physicians of London, the relative lack of practical influence of the medical elite in the period.[22] By undermining notions of the central role of qualified professionals, studies such as these question the validity of focusing on medicine in the eighteenth century solely in terms of a narrow elite.

As more detailed historical research been done in this area since the 1980s, the topic of professionalisation has not disappeared, but is largely incorporated into wider texts rather than viewed as a stand-alone subject for analysis.[23] Anita Guerrini, studying the 'pamphlet wars' of eighteenth-century practitioners, has identified the conflict between physicians regarding what constituted acceptable medical practice and which medical authorities should be considered as reliable sources of information.[24] The rivalries she has uncovered demonstrate how, for many practitioners, professional insecurity was pronounced in a period of significant social and medical change.[25] The rise of nosologies (i.e.

[18] See particularly Parry and Parry, *The Rise of the Medical Profession*, p.104-252.
[19] See, for example, Toby Gelfand, *Professionalizing Modern Medicine: Paris Surgeons and Medical Science and Institutions in the 18th Century* (London, 1980).
[20] Margaret Pelling, 'Medical Practice in the Early Modern Period – Trade or Profession?', *Society for the Social History of Medicine Bulletin*, 32:1 (1983), pp.27-30; Thomas H. Broman, *The Transformation of German Academic Medicine 1750-1820* (Cambridge, 1996), p.3.
[21] Broman, *The Transformation of German Academic Medicine,* p.6-7.
[22] Roy Porter, 'Before the Fringe: Quack Medicine in Georgian England', *History Today*, 36:11 (1986), pp.16-22.
[23] See, for example, Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (Oxford, 1999).
[24] Anita Guerrini, ' "A Club of Little Villains": Rhetoric, Professional Identity and Medical Pamphlet Wars', in W. F. Bynum and Roy Porter (eds), *Literature and Medicine During the Eighteenth Century* (London and New York, 1993), pp.227-238.
[25] Ibid.

attempts to systematically classify disease) during this period further demonstrates the desire by practitioners to provide a coherent basis for medical practice. Increasingly the disease theories of prominent nosologists such as the Edinburgh physician William Cullen have been identified, not as significant alterations to pre-existing understandings of medicine, but rather as attempts to simplify, synthesise, and compile the disparate theories on diagnosis, treatment, and cure which had been identified by their predecessors.[26]

The story of illness in the eighteenth century has often been posed as a dramatic one, with life-threatening diseases such as syphilis, consumption, and smallpox being the focus of a great deal of historiographical research.[27] More recently interest has grown in less critical conditions, particularly those relating to the skin, often in cross-disciplinary studies which have taken the manifestation of skin complaints and considered their broader social and cultural contexts.[28] The skin is only one of a number of physical attributes whose study has served to bridge the divide between medical and social history. When the English physician John Woodward wrote a study of contemporary medical practice in 1718, he opened with 'the Beginnings of all Things, good or bad, to the Body, are in the Stomach... Matter, vitious, and erroneous, in the Stomach, must unavoidably be diffused over and incommode the whole Frame'.[29] The historian Michael Schoenfeldt, studying the cultural history of the body in early modern England, has connected the focus of individuals such as Woodward on the stomach with changes in dietary habits and cultural constructs surrounding eating.[30] Humoral theory, according to Schoenfeldt, was central to these early modern interpretations of the stomach.[31] Jan Purnis, similarly, has considered how these

[26] Nima Bassiri, 'The Brain and the Unconscious Soul in Eighteenth-Century Nervous Physiology: Robert Whytt's Sensorium Commune', *Journal of the History of Ideas*, 74:3 (2013), pp.425-448.
[27] For a discussion on the focus of historical research on such subjects, see Jonathan Andrews, 'History of Medicine: Health, Medicine and Disease in the Eighteenth Century', *Journal for Eighteenth-Century Studies*, 34:4 (2011), pp.503-515.
[28] Barbara Duden, *The Woman Beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany* (Cambridge, MA, 1991); Claudia Benthien, *Skin: On the Cultural Border Between Self and the World* (New York and Chichester, 2002); Steven Connor, *The Book of Skin* (London, 2004); Nina G. Jablonski, *Skin: A Natural History* (London, 2006).
[29] John Woodward, *The State of Physick: And of Diseases; With an Inquiry into the Causes of the Late Increase of Them: But More Particularly of the Smallpox. With Some Considerations Upon the New Practice of Purgeing in That Disease. To the Whole is Premised, An Idea of the Nature and Mechanism of Man: Of the Disorders to Which it is Obnoxious: And of the Method of Recifying Them* (London, 1718), pp.1-2.
[30] Michael Schoenfeldt, 'Fables of the Belly in Early Modern England', in David Hillman and Carla Mazzio (eds), *The Body in Parts: Fantasies of Corporeality in Early Modern Europe* (London, 1997), pp.244-251.
[31] Ibid.

humoral principles resulted in contemporary understandings of how the stomach operated which were often gendered, class-based, and contained implied ethnic hierarchies.[32]

The analysis of disease in the late eighteenth and early nineteenth centuries, therefore, must consider such complaints not as fixed concepts but as changing entities. Early disease histories, replete with examples of retrospective diagnosis, frequently assumed, for example, that eighteenth-century use of the term typhus corresponded with modern day understanding of this disease.[33] More recently, historians have argued for caution in the use of this approach and have emphasised the potential inaccuracy it brings to historical studies.[34] The historian Jon Arrizabalaga has critiqued retrospective diagnosis, not only for the imprecision inherent in this approach, but also because it prevents the historian from understanding disease in its contemporary context.[35]

Instead, cultural constructions of the understanding of illness have increasingly taken a central position within the history of medicine. David Harley's work is of particular relevance in this context as he focuses on the use of rhetoric; how experiences of pain and sickness are based on cultural expectations and can vary, not just over time but also between different communities and individuals.[36] Ivan Dalley Crozier has continued this approach by arguing that historians still focus primarily on historical sources in terms of their content, while they should be taking greater account of the importance of the specific language which is used and the interactions which they represent.[37] There have subsequently been a range of publications focusing on the subject of cultural constructions of sickness, particularly on the history of specific medical conditions.[38]

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[32] Jan Purnis, 'The Stomach and Early Modern Emotion', *University of Toronto Quarterly*, 79:2 (2010), pp.800-818.
[33] W. P. MacArthur, 'Old-Time Typhus in Britain', *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 20:8 (1927), pp.487-503.
[34] Jon Arrizabalaga, 'Problematizing Retrospective Diagnosis in the History of Disease', *Asclepio: Revista de Historia de la Medicina y de la Ciencia*, 54:1 (2002), pp.51-70.
[35] Ibid.
[36] David Harley, 'Rhetoric and the Social Construction of Sickness and Healing', *Social History of Medicine*, 12:3 (1999), pp.407-435.
[37] Ivan Dalley Crozier, 'Social Construction in a Cold Climate: A Response to David Harley, 'Rhetoric and the Social Construction of Sickness and Healing' and to Paolo Palladino's Comment on Harley', *Social History of Medicine*, 13:3 (2000), pp. 535-546.
[38] See, for example, Sander L. Gilman, *Obesity: The Biography* (Oxford, 2010).

Since the 1990s the history of emotions has been a central component of this new area of research, connecting history with sociology, anthropology, and psychology.[39] In these studies, emotions such as shame, passion, and empathy are considered in the context of their social, literary, and political constructs. In the context of the history of medicine, the study of pain has proved particularly significant, from its medical treatment to its policing, articulation, and the ways in which it was influenced by contemporary popular culture.[40] The challenge inherent in such studies is to capture experiences of pain across all sectors of society. When sources are based primarily upon the written articulation of the individual's experiences this inevitably focuses research upon an educated minority. The study of the history of emotions can all too easily become the study of the experiences of the elite. Indeed, the concern that a focus on first-hand accounts weighs the historiography in favour of the study of the middle and upper classes is a recurring one in the writing on the subject.[41]

The study of the sick poor in the context of the institutions which admitted them, while suffering from limitations of its own, continues to be the major source for systematic study of this category of patients in the late eighteenth and early nineteenth centuries. The study of such institutions is, as Michael Brown has put it, the 'hardy perennial' of medical history.[42] While Jonathan Andrews notes they have fallen out of fashion somewhat in recent decades, he has similarly characterised institutional histories as the 'bread and butter' of medical historians.[43] Current perceptions of such studies have been impacted somewhat by the form which earlier examples took. Frequently commissioned by the institution, usually a hospital, to celebrate a significant anniversary, these works generally considered the

[39] Peter Stearns, *Shame: A Brief History* (Urbana, 2017); Heather Kerr, David Lemmings, Robert Phiddian (eds), *Passions, Sympathy and Print Culture: Public Opinion and Emotional Authenticity in Eighteenth-Century Britain* (New York, 2016); Ute Frevert, *Emotional Lexicons: Continuity and Change in the Vocabulary of Feeling 1700–2000* (Oxford, 2014).

[40] Lisa Wynne Smith, ' 'An Account of an Unaccountable Distemper': The Experience of Pain in Early Eighteenth-Century England and France', *Eighteenth-Century Studies*, 41:4 (2008), pp.459-480; Katherine A. Walker, 'Pain and Surgery in England, circa 1620– circa 1740', *Medical History*, 59:2 (2015), pp.255-274; Peter Stanley, *For Fear of Pain: British Surgery, 1790-1850* (New York, 2003)*;* Joanna Bourke, *The Story of Pain: From Prayer to Painkillers* (Oxford, 2014).

[41] See, for example, Elaine Leong, and Sara Pennell, 'Recipe Collections and the Currency of Medical Knowledge in the Early Modern 'Medical Marketplace' ', in Mark S. R. Jenner and Patrick Wallis (eds), *Medicine and the Market in England and its Colonies, c. 1450-c.1850* (Basingstoke, 2007), pp.134-137.

[42] Michael Brown, 'Jonathan Reinarz, Health Care in Birmingham: The Birmingham Teaching Hospitals, 1779–1939', *Social History of Medicine*, 23:2 (2010), p.436.

[43] Andrews, 'History of Medicine: Health, Medicine and Disease in the Eighteenth Century', p.505.

institution in isolation from wider society, focusing instead on its foundation, administration, and notable achievements.[44] Reflecting on these earlier studies Lindsay Granshaw has noted that 'it is sometimes difficult to detect that there actually were patients'.[45]

Although more traditional histories continue to be written, a study of Glasgow's Royal Hospital for Sick Children by Iain Hutchison, Malcolm Nicolson, and Lawrence Weaver being a notable example,[46] increasingly institutions are studied in the context of the wider community in which they are situated. In *Hospitals and Communities, 1100-1960* its editors, Christopher Bonfield, Jonathan Reinarz, and Teresa Huguet-Termes, have collected together case studies which consider a diverse array of communities both created by, and impacting upon, hospitals.[47] These communities range from the networks of patrons and the camaraderie of patients, to tradesmen, medical staff, and even the thieves who stole from those institutions.[48] This publication is part of a wider research network which has significantly revitalised the study of medical institutions.

Indeed, the study of medical institutions more generally has experienced somewhat of a resurgence in recent decades. Medical treatment within workhouses, alongside a growing body of work relating to medical out-relief, has been significantly advanced, particularly in the writing of Jonathan Reinarz, Leonard Schwarz, and Kevin Siena.[49] The history of asylums has also proved of interest, both in the context of individual institutions

[44] Turner A. Logan, *Story of a Great Hospital. The Royal Infirmary of Edinburgh 1729-1929* (Edinburgh, 1979); William Brockbank, *Portrait of a Hospital, 1752-1948: To Commemorate the Bi-centenary of the Royal Infirmary, Manchester* (London, 1952).
[45] Lindsay Granshaw, 'Introduction', in Lindsay Granshaw and Roy Porter (eds), *The Hospital in History* (London and New York, 1990), p.1.
[46] Iain Hutchison, Malcolm Nicolson, and Lawrence Weaver, *Child Health in Scotland: A History of Glasgow's Royal Hospital for Sick Children* (Erskine, 2016).
[47] Christopher Bonfield, Jonathan Reinarz, and Teresa Huguet-Termes (eds), *Hospitals and Communities, 1100-1960* (Bern, 2013).
[48] Ibid.
[49] These works include: Jonathan Reinarz and Leonard Schwarz (eds), *Medicine and the Workhouse* (Rochester and Suffolk, 2013); Kevin Siena, 'Hospitals for the Excluded or Convalescent Homes?: Workhouses, Medicalization and the Poor Law in Long Eighteenth-Century London and Pre-Confederation Toronto', *Canadian Bulletin of Medical History*, 27:1 (2010), pp.5-21; Alannah Tomkins, *The Experience of Urban Poverty, 1723-82: Parish, Charity and Credit* (Manchester and New York, 2006). The body of work relating to poor relief more generally is too extensive to discuss in detail here but includes, particularly, the writing of Steven King and Peter Jones.

and in relation to regional variations in asylum development and practice.[50] Increasingly hospitals, workhouses, and asylums have been studied collectively.[51] An emphasis on confinement and isolation and the impact which these had on both patients and wider communities can be witnessed in a range of studies.[52] In a further development of this approach one recently published collection on residential institutions, covering the period from 1725 to 1970, has combined the study of hospitals, workhouses, and asylums with non-medical institutions such as university halls of residence and military living quarters.[53] Unfortunately, as is the case with many studies that cover such a broad time span, the work is weighted in favour of the later period, with far less detail provided relating to the eighteenth and early nineteenth centuries.[54] However, according to this study, analysing the immersive and formative experience of residential systems over more than 200 years provides significant commonalities between such disparate institutions.[55]

The place of dispensaries within this branch of research is less clear. As non-residential institutions whose treatment model was less immersive than their infirmary and workhouse counterparts, they do not fit neatly within the current approaches to institutional history. An article by Alun Withey on Northumberland's Bamburgh dispensary stands out as a rare example of a recent detailed study of eighteenth-century dispensary practice.[56] Withey's work, while serving primarily to demonstrate the anomalous nature of this isolated institution, provides insight into the expansive medical services which could be made available in such a remote district. Broadly, however, the study of eighteenth- and early nineteenth-century dispensaries still remains to be advanced in the twenty-first century. Equivalent institutions in continental Europe have not fared much better.

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[50] Leonard Smith, 'Lunatic Asylum in the Workhouse: St Peter's Hospital, Bristol, 1698–1861', *Medical History*, 61:2 (2017), pp.225-245; Jennifer Wallis, *Investigating the Body in the Victorian Asylum: Doctors, Patients and Practices* (Cham, 2017).

[51] Norbert Finzsch and Robert Jütte (eds), *Institutions of Confinement: Hospitals, Asylums, and Prisons in Western Europe and North America, 1500–1950* (Cambridge, 2003); Graham Mooney and Jonathan Reinarz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (Amsterdam and New York, 2009).

[52] Ibid.

[53] Jane Hamlett, Lesley Hoskins and Rebecca Preston (eds), *Residential Institutions in Britain, 1725-1970: Inmates and Environments* (London and Brookfield, 2013).

[54] Only a single chapter in the collection relates to the period prior to 1870: Jeremy Boulton and John Black, 'Paupers and Their Experience of a London Workhouse: St Martin-in-the-Fields, 1725-1824'.

[55] Jane Hamlett with Lesley Hoskins and Rebecca Preston, 'Introduction', in Jane Hamlett, Lesley Hoskins and Rebecca Preston (eds), *Residential Institutions in Britain, 1725-1970: Inmates and Environments*, pp.1-15.

[56] Alun Withey, 'Medicine and Charity in Eighteenth-Century Northumberland: The Early Years of the Bamburgh Castle Dispensary and Surgery, c.1772-1802', *Social History of Medicine*, 29:3 (2016), pp.467-489.

Stephanie Neuner and Karen Nolte, in a study of nineteenth-century German policlinics, bodies which were largely analogous to British dispensaries, have noted how such outpatient facilities have largely been ignored in the existing literature.[57]

The two most recent monograph works on dispensaries – one, a study of the Whitehaven dispensary in Cumbria, and the other a general overview of the history of British dispensaries – have both been written by medical practitioners and very much follow the model of earlier institutional histories rather than being influenced by more recent methodological developments.[58] It is necessary, therefore, to return to the previous century in order to uncover more in-depth literature on this subject. While there are no full-length monographs, beyond those previously mentioned, the topic has been explored in a number of journal articles and included in a range of studies on charity, public health, and poor law provision. These works often share similar information, providing brief summaries of the history of the dispensary movement.[59]

Articles which provide more in-depth information on eighteenth-century dispensaries have, in the main, used publications, both primary and secondary, for their source material.[60] Where manuscript material has been used, it has, in large part, been accessed either as a source for administrative histories or to analyse the aims of both the founders and funders of these institutions. One exception to this is an occasional paper by Marland on the Doncaster dispensary which includes a detailed breakdown of diseases and treatments of patients.[61] The main conclusion which must be drawn, however, is that a relatively small amount of attention has been paid to the subject of dispensaries in the

[57] Stephanie Neuner and Karen Nolte, 'Medical Bedside Training and Healthcare for the Poor in the Würzburg and Göttingen Policlinics in the First Half of the Nineteenth Century', in Martin Dinges, Kay Peter Jankrift, Sabine Schlegelmilch and Michael Stolberg (eds), *Medical Practice, 1600-1900: Physicians and Their Patients* (Leiden, 2016), pp.207-209.

[58] Michael Sydney, *Bleeding, Blisters and Opium: Joshua Dixon and the Whitehaven Dispensary* (Workington, 2009); Michael Whitfield, *The Dispensaries: Healthcare for the Poor Before the NHS, Britain's Forgotten Health-care System* (Bloomington, 2016).

[59] These include: Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London, 1997), p.299; Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950* (London and New York, 2001), pp.89-92.

[60] See, for example, I. S. L. Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine*, 55:3 (1981), pp.322-342; William Hartston, 'Medical Dispensaries in Eighteenth Century London', *Proceedings of the Royal Society of Medicine*, 56 (1963), pp.753-758.

[61] Hilary Marland, *Doncaster Dispensary 1792-1867: Sickness, Charity and Society (Occasional paper)* (Doncaster, [1989]).

existing literature and, where they have been considered, their patients have largely been neglected.

The three dispensaries which are the focus of this study are no exception. The Edinburgh dispensary has received scant attention and where it is discussed it has been given little more than a cursory mention in most cases.[62] The reason for this dispensary's omission from many studies is in part a result of their focus on English, and particularly London-based, examples, a focus which has been noted by, among others, medical practitioner and historian Stuart Anderson.[63] Zachary Cope, in an article on the subject of dispensary teaching, largely glosses over the work of the Edinburgh dispensary in this field, stating only that its founder, Andrew Duncan, 'more than likely' taught at his dispensary; such phrasing implies that this is not clear, in spite of the fact that Duncan published many times on the subject of his dispensary teaching practice.[64]

There are two additional main secondary sources relating to the Edinburgh dispensary, both of which take the form of biographies of Duncan. The first is a short publication by the historian Lisa Rosner and the second a collection of essays edited by the retired surgeon John Chalmers.[65] The latter contains a chapter which gives a general overview of the dispensary's history, written by the anatomist and historian Matthew Kaufman.[66] This text relies primarily on Duncan's published works and does not utilise the extensive collection of manuscript notes kept by Duncan relating to his dispensary practice, the contents of which will be analysed in detail in this thesis. As a result, Kaufman's writing only provides a limited overview of dispensary patients and the treatments they received. The reliance of the secondary literature on a small number of printed sources, particularly those which served to publicise and promote the institution, has resulted in a particular

[62] See, for example, Lindsay Granshaw, 'The Rise of the Modern Hospital in Britain', in Andrew Wear (ed.), *Medicine in Society: Historical Essays* (Cambridge, New York, and Melbourne, 1996), p.206. Granshaw states here that Andrew Duncan founded the dispensary while he was Professor of the Institutes of Medicine, while in fact Duncan, at that point, was not employed by the University of Edinburgh and was instead teaching privately.

[63] Stuart Anderson, 'The Dispensary Movement, Apothecaries and the Supply of Medicines 1696 to 1949', *Pharmaceutical Historian*, 39:2 (2009), p.18.

[64] Zachary Cope, 'The Influence of the Free Dispensaries Upon Medical Education in Britain', *Medical History*, 13:1 (1969), p.30.

[65] Lisa Rosner, *Andrew Duncan (1744-1828), F.R.S.E.* (Edinburgh [1981]); John Chalmers (ed.), *Andrew Duncan Senior: Physician of the Enlightenment* (Edinburgh, 2010).

[66] M. H. Kaufman, 'Edinburgh's Royal Public Dispensary', in John Chalmers (ed.), *Andrew Duncan Senior: Physician of the Enlightenment* (Edinburgh, 2010), pp.56-70.

focus on the administrative side of the dispensary rather than detailed study of its patients and their treatment.

The Kelso dispensary has received even less attention within the literature. There exists one self-published booklet which was written by a local practitioner in the 1980s that touches on the history of the dispensary, although this comprises only a minor section in a small publication which has a broad coverage, its subject matter ranging from the twelfth to the twentieth centuries.[67] The most detailed study of the Kelso dispensary was carried out by a member of its staff, Charles Wilson, in the first half of the nineteenth century.[68] In this work Wilson compared the patient records for two ten year periods, 1777 to 1787 and 1829 to 1839. He considered the most common diseases treated as well as surrounding living conditions and rates of mortality and clearly had access to volumes of, now missing, physicians' case books to assist in his analysis. One subject of particular interest for Wilson was the level of admission of ague, or intermittent fever, cases in the earlier period which had ceased almost entirely by the 1830s.[69] What little further analysis in the secondary literature that exists regarding the Kelso dispensary has tended to focus on the subject of ague, commonly referencing Wilson's study rather than utilising archival sources.[70]

The Newcastle dispensary has, comparatively, fared rather better in the existing literature. The earliest secondary account published concerning the Newcastle dispensary was written by a member of its medical staff, John Fenwick, in 1806.[71] This took the form of a biographical study of the dispensary's founder, John Clark, detailing his upbringing, his professional work, and his medical publications. This was created as a eulogy to Clark, however, and the resulting bias in its approach is clear from the lengthy discussions it contains regarding his apparently commendable personality, remarkable memory, and great benevolence.[72] Further detailed study of the Newcastle dispensary was not undertaken until

[67] J. L. Trainer, *The Doctors of Kelso: A History of Medical Care in the Town and District* (Berwick, [1987]).
[68] Charles Wilson, 'Statistical Observations on the Health of the Labouring Population of the District of Kelso, in Two Decennial Periods, from 1777 to 1787, and from 1829 to 1839', *The Quarterly Journal of Agriculture*, 12 (1842), pp.317-355.
[69] Ibid., pp.328-329.
[70] John D. Comrie, *History of Scottish Medicine, Volume Two* (London, 1932), pp.430-431; J. H. F. Brotherston, *Observations on the Early Public Health Movement in Scotland* (London, 1952), pp.26-29; Guenter Risse, *New Medical Challenges during the Scottish Enlightenment* (Amsterdam and New York, 2005), pp.180-181.
[71] J. R. Fenwick, *Sketch of the Professional Life and Character of John Clark, M.D. Fellow of the Royal College of Physicians at Edinburgh &c. &c.* (Newcastle, 1806).
[72] Ibid, pp.9-10, p.16, p.30 and pp.43-53.

the late twentieth century, with the personality and professional work of Clark once again at the fore. This more recent work has been carried out by another Newcastle physician, Frederick Miller, who has made a concerted effort to unearth the history of Clark, who Miller describes in one of his publications as 'the forgotten physician'.[73] In this work, similar ground is covered to that of Fenwick's book, although the approach taken here is more balanced, with greater attention given to information contained in primary sources.

More detailed analysis of the Newcastle dispensary was carried out recently by the historian Graham Butler in a thesis which considers the work of the dispensary alongside the medical treatment for the poor offered by the Newcastle infirmary and local Poor Law authorities.[74] Butler carried out quantitative analysis of dispensary patient records, looking at their breakdown in the context of patient age, sex, rates of admission, medical diagnosis, and mortality rates.[75] Butler's thesis is the first time eighteenth-century dispensary patient records have been considered in such detail in the literature and, while his study is restricted to the city of Newcastle and refers primarily to admission registers and annual reports rather than more detailed sources such as case notes, it provides an example of approaches to studying such records and a starting point for the comparative analysis of that dispensary with other institutions which this thesis will undertake.

Introduction to the Sources

The sources which have provided the basis for much of the historical analysis of medical institutions have been the printed materials which they created in order to promote their work and encourage public donations. Amongst the most common of these printed materials were institutional annual reports. Those examples of such reports which were produced by the Edinburgh, Kelso, and Newcastle dispensaries are considered here both for the insight they provide into the work of these dispensaries and for the light they shed on the ways in which the dispensaries were portrayed to the public. In this context, the present analysis will also make use of other sources which were authored on behalf of the

[73] F. J. W. Miller, 'Dr John Clark: The Forgotten Physician, 1744-1805', in D. Gardner-Medwin; A. Hargreaves and E. Lazenby (eds), *Medicine in Northumbria: Essays in the History of Medicine in the North East of England* (Newcastle, 1993).
[74] Graham A. Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne, c.1750-1850' (Ph.D. diss., Newcastle University, 2012).
[75] Ibid, pp.155-213.

dispensaries, such as entries in newspapers, contemporary journal articles, and printed pamphlets. Although many of these printed works have already been analysed in the secondary literature, a comparative study of this material will allow for greater understanding of the variations between them.

In addition to these printed sources, there is one resource which is unique to a single institution. These are the manuscript patient case notes of the Edinburgh dispensary. This collection, which contains approximately 5000 individual patient entries, covers the period from 1774 to 1816.[76] Apparently kept for teaching purposes, these case notes provide significant insight, not only into the services which the dispensary provided, but also into the lives of the dispensary's patients. From this collection information can be gathered regarding their employment, age, gender, and family circumstances. This research fills a gap in the existing literature because, as previously noted, while a contemporary published selection of these cases has been analysed by Kaufman, the original and far more comprehensive manuscript collection has thus far not been studied. Furthermore, no equivalently detailed records have been identified for any other eighteenth-century British dispensary.[77]

It has been over fifty years since Erwin Ackerknecht highlighted the usefulness of patient case notes for the study of both the practices of non-elite physicians and the experiences of their patients.[78] Guenter Risse, an early adopter of this approach, has used case notes from the Edinburgh infirmary[79] to uncover not only methods of diagnosis and treatment, but also the relationships between patients and practitioners.[80] Since Risse's

[76] The pre-1776 records in this collection relate to Duncan's private practice, while the post-1790 records comprise patient case notes from both the Edinburgh dispensary and the Edinburgh infirmary.
[77] A small number of cases from other dispensaries can be found in printed sources. See, for example, John Coakley Lettsom, *Medical Memoirs of the General Dispensary in London, For Part of the Years 1773 and 1774* (London, 1774), pp.23-118; pp.135-151; pp.158-163; pp.206-240; pp.266-307; pp.309-342.
[78] Erwin H. Ackerknecht, 'A Plea for a 'Behaviourist' Approach in Writing the History of Medicine'*, Journal of the History of Medicine and Allied Sciences*, 22:3 (1967), pp.211-214.
[79] The formal title of the Edinburgh infirmary at this time was the Royal Infirmary of Edinburgh. As, however, each of the medical institutions studied here was known by a variety of names, the convention adopted in this thesis is to use shortened versions of their names. For example, the formal title of the Newcastle infirmary was commonly recorded as 'The Infirmary for the Sick and Lame Poor of the Counties of Durham, Newcastle Upon Tyne, and Northumberland'. For ease of understanding, therefore, it will be known as the Newcastle infirmary. Likewise for the Edinburgh dispensary, Kelso dispensary, and Newcastle dispensary.
[80] Risse utilised these infirmary patient records in a number of studies. The references given here relate only to those most pertinent to this analysis. Guenter Risse, ' "Typhus" Fever in Eighteenth-Century Hospitals: New Approaches to Medical Treatment', *Bulletin of the History of Medicine*, 59:2 (1985), pp.176-195; Guenter Risse, *Hospital Life in Enlightenment Scotland: Care and Teaching at the Royal Infirmary of Edinburgh* (Charleston,

initial forays into this subject in the 1980s and 1990s subsequent research has increased and enhanced approaches to the study of patient case notes. While some historians, such as David Shephard, Henrik Wulff, and Kristen Jungersen, have continued to focus primarily on what these sources can tell us about the individual practitioner,[81] others have used case notes to develop comparative studies of medical practices and to uncover differing treatment models applied to particular demographics of patients.[82] Large-scale research and digitisation projects began to be undertaken in the early 2000s and their labours have produced international conferences, publications, and online databases of their source material.[83] This research has also served to align the work of medical historians more closely with current research being undertaken within the field of social history relating to concepts of community and kinship and to the study of particular groups such as the elderly, children, and pregnant women.[84]

There are distinct challenges, however, in the analysis of patient case notes. While methodologies for the study of such records have been developed, including by Guenter Risse and John Harley Warner,[85] application of these methods relies on the availability of certain information relating to these sources. It is certainly useful to know when a practitioner recorded his notes (for example, immediately after the medical consultation, at

2010); Guenter Risse, 'Hysteria at the Edinburgh Infirmary: The Construction and Treatment of a Disease, 1770-1800', *Medical History*, 32 (1988), pp.1-22; Risse, *Mending Bodies, Saving Souls: A History of Hospitals*.

[81] David Shephard, 'The Casebook, the Daybook, and the Diary as Sources in Medical Historiography', *Canadian Bulletin of Medical History*, 17 (2000), pp.245-255; Henrik R. Wulff and Kirsten Jungersen, 'A Danish Provincial Physician and His Patients: The Patient Records from the Practice of Christopher Detlev Hahn in Aarhus around 1800', *Medizinhistorisches Journal*, 40 (2005), pp. 321-345.

[82] Lauren Kassell, 'Casebooks in Early Modern England: Medicine, Astrology, and Written Records', *Bulletin of the History of Medicine*, 88:4 (2014), pp.595-624; Robert Woods and Chris Galley, *Mrs Stone & Dr Smellie: Eighteenth-Century Midwives and their Patients* (Liverpool, 2014); Hannah Newton, 'Children's Physic: Medical Perceptions and Treatment of Sick Children in Early Modern England, c.1580-1720', *Social History of Medicine*, 23:3 (2010), pp.456–474.

[83] For more detailed discussions of these projects, see: Martin Dinges and Michael Stolberg, 'Introduction', in Martin Dinges, Kay Peter Jankrift, Sabine Schlegelmilch and Michael Stolberg (eds), *Medical Practice, 1600-1900: Physicians and Their Patients* (Leiden, 2016), pp.1-7; Jenny Mitcham, 'Digitizing a Hospital Archive: The Retreat, York', *Journal of Victorian Culture*, 23:2 (2018), pp.238-246.

[84] This body of research is too extensive to discuss in detail here but includes the following works: Helen Berry and Elizabeth Foyster (eds), *The Family in Early Modern England* (Cambridge and New York, 2007); Susannah R. Ottaway, L. A. Botelho and Katharine Kittredge (eds), *Power and Poverty: Old Age in the Pre-Industrial Past* (Westport, 2002); Jaynay Nugent and Elizabeth Ewan (eds), *Children and Youth in Premodern Scotland* (Woodbridge, 2015); Nora Doyle, *Maternal Bodies: Redefining Motherhood in Early America* (Chapel Hill, 2018).

[85] Guenter Risse and John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, 5:2 (1992), pp.183-205; John Harley Warner, 'The Uses of Patient Records by Historians: Patterns, Possibilities and Perplexities', *Health and History*, 1:2/3 (1999), pp.101-111.

the end of the day, the end of the week, etc.) and who the scribe was (whether the practitioner themselves or an assistant or clerk). Such contextual data, however, may not always be available to the historian. Andrews, in a study of the Gartnavel Royal Asylum in Glasgow, has noted additional difficulties in utilising such material, including the self-censorship of case-note authors when detailing symptoms of a sexual nature.[86] Additionally, and perhaps most importantly, it is necessary to question how representative these records are, both in terms of the practitioners who created them and the patients they describe.

In the case of Risse's work, the case notes used in his analysis only contain information pertaining to patients in the Edinburgh infirmary's teaching ward.[87] This ward was separated from the infirmary's general admission wards and was comprised of patients who were individually selected for further study by the infirmary's medical staff. They were, therefore, a subset of the sick who were admitted to that institution. They were individuals who had been chosen because they were viewed as displaying particularly interesting or unusual symptoms. A different selection process was underway in the other case-note collections discussed above. More recent research has predominantly focused on patient notes from physicians' private practices. Martin Dinges and Michael Stolberg, in their introduction to a study which resulted from a major Austrian, German, and Swiss collaboration, emphasise that effort was made to include records relating to poorer patients and asserted that 'more or less all walks of society' are covered by the data which has been accumulated during the course of this project.[88] Outside of charitable relief systems, however, the extent to which the very poorest members of society are represented in these case notes is open to question.[89]

It is important to explain the omissions, as well as inclusions, in the present study. This is particularly relevant in the context of archival manuscript material. While all three dispensaries created patient registers, minute books, and other day-to-day records detailing the work they carried out, not all of these records have survived. The Kelso dispensary has

[86] Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11:2 (1998), pp.255-281.
[87] Risse, *Hospital Life in Enlightenment Scotland*, p.5.
[88] Dinges and Stolberg, 'Introduction', pp.5-7.
[89] More effort was made in this particular study to include poorer patients than is often the case. This is particularly apparent in two chapters, the first relating to two nineteenth-century outpatient clinics and the second concerning an unlicensed healer. Neuner and Nolte, 'Medical Bedside Training and Healthcare for the Poor in the Würzburg and Göttingen Policlinics in the First Half of the Nineteenth Century', pp.207-229; Alois Unterkircher and Iris Ritzmann, 'Unlicensed Practice: A Lay Healer in Rural Switzerland', pp.230-252.

the most comprehensive records, with both minute books and patient registers existing for most of the period under study here.[90] Equivalent records for the Edinburgh and Newcastle dispensaries, whilst certainly created, do not appear to have survived.[91] In addition, little correspondence exists from the medical staff of these dispensaries. Only scraps remain, a few individual letters which were preserved by their recipients. The published writings of dispensary founders, Duncan and Clark, will be studied in order to fill this gap in the manuscript records.

Contemporary medical texts and manuscripts will be explored, including the work of prominent eighteenth-century medical practitioners such as William Cullen and Sir John Pringle. In doing so, context will be given for the treatments which were provided by the dispensaries based on contemporary rationales for diagnosis and treatment. This will provide insight into which dispensary treatments were considered commonplace by the wider medical community and which were innovations of the dispensaries themselves. The need for caution, however, will be emphasised when considering these sources. Disease terminology in this period was in a state of flux and the impact of the reclassification of certain terms must be considered alongside changes in the lived experiences of illness.

This research will also make use of other contemporary sources, including minute books and patient records from the infirmaries and workhouses in Edinburgh and Newcastle and kirk session minutes from Kelso. The records of other local medical charities will also be considered, including those relating to the Edinburgh and Newcastle lying-in charities to support women during and after childbirth. The purpose of this vein of research is to uncover the local context of dispensary relief, to consider the existing models of support available to the sick poor in those districts when the dispensaries were founded, and to consider how these developed over the course of the late eighteenth and early nineteenth

[90] The Kelso dispensary annual reports and minute books provide a continuous series for the period under study here, with the exception of one year, 1809, for which no report has been identified. The dispensary's admission registers are missing for the years from 1786 to 1790.

[91] Reference to the Newcastle dispensary's patient registers, as well as their preservation of patient letters of recommendation, is made in a publication by Clark. John Clark, *Observations on Fevers, Especially Those of the Continued Type; and on the Scarlet Fever Attended with Ulcerated Sore-Throat, as it Appeared at Newcastle Upon Tyne in the Year 1778* (London, 1780), p.190. Reference is also made elsewhere to the compilation of monthly summaries of patient cases. Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1790), p.21. Similarly, the Edinburgh dispensary records note that a register of patient cases was kept. Anon., *[List of Regulations of the Public Dispensary of Edinburgh, Agreed to by its Subscribers]* [Edinburgh, 1777], p.1.

centuries. This information can then demonstrate the gaps within this provision and the role which the dispensaries played in filling these gaps.

To provide a framework for analysis, local economic, social, and environmental conditions in the geographical areas under consideration will be considered through the study of a range of contemporary sources. This includes, in the cases of Edinburgh and Kelso, John Sinclair's *The Statistical Account of Scotland*, a series of volumes produced in the 1790s to give a range of information on all the parishes of Scotland. Contemporary studies and histories will also be examined for all three districts. In the case of Kelso, these works were commonly written by travellers passing through the district, while for Edinburgh and Newcastle more detailed texts exist which provide in-depth information on local employment, civic institutions, and charities.

Methodology

The widespread nature of dispensary provision in the late eighteenth and early nineteenth centuries, with dispensaries being founded in cities, towns, and villages across Britain, raises the question: Why have these particular dispensaries been selected as the subject of study? Analysis of the three dispensaries provides the opportunity to consider these burgeoning institutions in diverse but also comparable contexts. They share a similar timeline, with the Edinburgh dispensary having been established in 1776 while the Kelso and Newcastle dispensaries were founded the following year. They also all proved to be, in a sense, successful. All survived into the twentieth century, while many other charitable undertakings had significantly shorter lifespans.[92] In addition, the dispensaries were all founded as distinct institutions, not managed by or attached to an infirmary, workhouse, or other public enterprise. They were not offshoots of existing civic or charitable enterprises or founded as the result of bequests, but rather built by their staff, managers, and donors from the ground up.[93]

Differences in their circumstances, however, also allow for the study of differences in their foundations, development, and management models. By drawing comparisons

[92] Less successful models of dispensary operation, including that of the London Dispensary for the Infant Poor, will be discussed in more detail in chapter two.
[93] The foundation models of these dispensaries could take a wide range of forms. For a more detailed discussion of this subject see Marland, *Doncaster Dispensary*, pp.13-21.

between the charitable medical relief available in three localities – an industrialising city in the north of England, a Scottish border town, and Scotland's capital city – this thesis complicates studies from the existing historiography of medical provision for the sick poor in the later eighteenth and early nineteenth centuries. While many studies have painted charitable medical relief in England and Scotland with broad brushstrokes, few detailed studies have been carried out of the areas under consideration here. The extent of regional variation, changes over time, and differences in local need and local resources are disguised in such general studies and the Edinburgh, Kelso, and Newcastle dispensaries, while sharing certain approaches, provide examples of distinct practices to suit specific local circumstances.

In addition to studying such contextual factors, quantitative analysis of the dispensaries will be carried out, utilising the patient case notes, admission registers, and annual reports. Variables, including name, gender, age, occupation, diagnosis, and treatment have been captured in a database. The classification of the medical components of this database are derived from Risse's taxonomy, created during his work on the Edinburgh infirmary.[94] Risse's categorisation has the advantages of both using contemporary terms and also being hierarchical, so medical conditions can be collated for analysis both at the level of syphilis or gonorrhoea and at the higher level of genito-urinary diseases (see Appendix). A further advantage to this approach is that Risse's classification of diseases and symptoms has more recently been adopted by a number of historians and so use of this method allows for cross-comparison between the findings made here and other studies.[95] However, Risse's categories have not been treated as definitive and have been developed and amended where necessary during the data collection process.

Research on the case notes from the Edinburgh dispensary forms part of a larger project underway at the Royal College of Physicians of Edinburgh, part-funded by the Wellcome Trust, to digitise this collection and make it available online.[96] The complexities inherent in this indexing work, however, must be acknowledged. Unlike the annual reports

[94] Guenter B. Risse, 'Hospital History: New Sources and Methods', in Roy Porter and Andrew Wear (eds), *Problems and Methods in the History of Medicine* (Beckenham, Surry Hills and New York, 1987), pp.180-181.
[95] Anne Borsay*, Medicine and Charity in Georgian Bath: A Social History of the General Infirmary, c.1739-1830* (Aldershot, 1999); Aylsa Levene, Jonathan Reinarz and Andrew Williams, 'Child Patients, Hospitals and the Home in Eighteenth-Century England', *Family & Community History*, 15:1 (2012), pp.15-31.
[96] Wellcome Research Resources Award, 'Andrew Duncan and the Public Dispensary: Patient Records, Treatment, and Training' (2016, 201718/Z/16/Z).

and admission registers, the case books are text-based and not tabular, so the material has been converted to a spreadsheet-appropriate form. However, data has not been normalised. For example, in the case of medical conditions and symptoms, where there is variation in terminology between Risse's categories and the description given in the records, both versions have been recorded. An excessive focus on formulaic categories to simplify analysis can lead to the loss of useful information, a concern which is highlighted repeatedly in the literature on quantitative analysis, so attempts have been made to avoid this form of data loss as far as possible.[97]

A similar process has been adopted for the study of the Edinburgh and Newcastle infirmary admission registers. Although infirmaries are not the primary focus of this analysis in order to provide meaningful context and comparison with the dispensaries quantitative analysis of patient admissions and treatment at other local institutions is essential. As errors were identified in the data collection methods of Risse in his study of the Edinburgh infirmary, the decision has been taken to rely on primary, rather than secondary, sources for this analysis.[98]

Aims and Objectives

This thesis explores late eighteenth- and early nineteenth-century British public health through a comparative study of the Edinburgh, Kelso, and Newcastle dispensaries. The study includes the administrative models of these dispensaries but also looks beyond these; it considers the forms which dispensary treatment took, the constraints and opportunities which such treatment provided, and how they were received, both by patients and by the wider community. In doing so, it focuses on the experiences of the sick poor, a group who have been less well served by eighteenth-century historiographical studies than their socially and financially better-off counterparts.

In addition, two subjects of note in the existing historiography are addressed. Firstly, the context of the foundation of dispensaries and their subsequent development will be explored. Reflecting this objective, this thesis will consider the scope of dispensary

[97] R. J. Morris, 'Document to Database and Spreadsheet' in Simon Gunn and Lucy Faire (eds), *Research Methods for History* (Edinburgh, 2012), p.143; Pat Hudson, *History by Numbers: An Introduction to Quantitative Approaches* (London, 2000), p.12.
[98] Further analysis of Risse's findings are discussed in more detail in chapters one and six.

provision, demonstrating that the number of individuals treated was often comparable to, even sometimes surpassing, levels at infirmaries and under local poor law systems. While the historiography of eighteenth-century infirmaries and poor relief is certainly more comprehensive than that of dispensaries, the research here seeks to uncover the significant and unique role which dispensaries played in medical provision for the sick poor. Looking beyond merely the number of patients who were admitted by these institutions, it will also consider the particular demographics of individuals who were treated and consider the extent to which these groups had previously been excluded from other forms of charitable relief.

The second major aim is to explore the practical application, as well as theoretical frameworks, of medical treatment during the late eighteenth and early nineteenth centuries. By giving priority to practice over theory, insight will be provided into the medical treatments which were commonly adopted by practitioners. In doing so it will also uncover the context of these treatments; not only which diagnoses they aimed to ameliorate, but the patients' symptoms and the identified outcomes of these treatments. This approach also enables analysis of the reception of these treatments by patients. While the patient's own voice in these interactions can rarely be identified and, therefore, must be mediated through that of the practitioner, the documented responses of patients demonstrates their agency in these medical encounters. The assumption will be questioned that a patient who was receiving treatment under the model of charitable medical relief was merely a passive recipient. Instead, it will be demonstrated that many such patients showed suspicion towards, or even outright refusal of, certain treatments which would otherwise appear to have been commonplace when findings are based on theoretical medical texts.

By addressing these aims the broad range of roles which eighteenth-century dispensaries played in medical provision will be revealed, a subject which has yet to be examined in detail by historians. By undertaking an in-depth comparative study of the Edinburgh, Kelso, and Newcastle dispensaries, differences and similarities in the foundation, administration, and undertakings of these dispensaries will be highlighted. This approach will offer fresh perspectives into the purpose and scope of dispensaries during the late eighteenth and early nineteenth centuries. The functional model of the Kelso dispensary, whereby the main aim of supplying treatment to the sick poor remained paramount throughout this period, will be contrasted with the more innovative approaches of the

Edinburgh and Newcastle dispensaries. In the case of the Edinburgh dispensary, this includes work in the areas of experimental new treatments and medical education and, in the case of the Newcastle dispensary, this took the form of public health developments in areas such as vaccination and hygiene. It will be demonstrated that these dispensaries, more so than their infirmary counterparts, did not view their remit as merely the treatment of patients but also the advancement of medical science and improvement of public health and wellbeing.

Chapter Synopsis

The thesis is divided into two sections. The first will address the broader context of the Edinburgh, Kelso, and Newcastle dispensaries and their administration. By considering wider medical relief in the surrounding districts as well as the foundation, management, and operation of the dispensaries, the first two chapters will uncover the impact which local circumstances had on dispensary operations. Chapter one lays the foundations by examining the range and evolution of resources available to the sick poor in the locality of the dispensaries. It will examine the infirmaries of Edinburgh and Newcastle, uncovering the economic, geographical, and social factors which, for many individuals, limited access to their services. It will then consider medical provision under the Old Poor Law. The differing models of poor relief in England and Scotland will be analysed as well as additional regional variations between the districts under consideration here. In doing so, it will be argued that variations in local charitable relief models impacted directly on the dispensaries, not necessarily in providing impetus for their foundation, but rather in determining the levels of local support for these new enterprises.

Chapter two will examine the operational models of the dispensaries. Initially it will consider the origins of the Edinburgh and Newcastle dispensaries, including the establishment of both institutions by young physicians who were relative outsiders to the medical establishments in their respective cities in terms of both their geographical and social origins. It will then contrast these findings with the form which the Kelso dispensary took, highlighting the role of local gentry and religious authorities in its foundation. The contrasts between these institutions will also be considered in the context of their levels of financial support and the local opposition or, in the case of the Kelso dispensary, lack

thereof, to their establishment. These variations will be considered for the impact which they had on dispensary management models, staffing, and policies surrounding their governance. Taking a comparative approach to the study of these institutions will enable the identification of different roles which dispensaries played in disparate regions.

The second part of this thesis will then turn to the practical undertakings of the dispensaries, focusing on their patients and the medical treatments which were provided. Chapter three will analyse the demographics of the Edinburgh, Kelso, and Newcastle dispensary patients, particularly in the context of employment, gender, and age. Distinct differences will be demonstrated between the findings of this study and studies which have been carried out previously of other eighteenth-century medical institutions. In particular, it will demonstrate how these dispensaries were more accessible to women and to non-working-age individuals than their infirmary counterparts.

Chapter four will then examine the methods of diagnosis which were adopted by dispensary medical staff. It will begin by exploring systems of disease classification in the late eighteenth and early nineteenth centuries, but will also look beyond these to consider their practical application in a dispensary context. This chapter will then consider the use of both physical and verbal methods of examination in the diagnosis of dispensary patients. It will be argued that, by contrast to historiographical findings in relation to infirmaries, dispensary physicians relied on the patients' own narratives regarding their medical complaints well into the nineteenth century.

Chapter five will further the study of dispensary methods of diagnosis by focusing on two particular categories of complaint: genito-urinary diseases and diseases of the digestive system. It will begin by considering how the foundation of dispensaries created new opportunities for the sick poor to seek treatment for conditions which were not accepted elsewhere, such as venereal complaints, and non-critical conditions such as constipation and intestinal worms. It thereby eschews the focus which is commonly placed by historians on the study of acute, fatal, and contagious diseases, instead paying particular attention to the more mundane, chronic, and everyday complaints of the sick poor. By considering not only the diseases which people died from but, perhaps more importantly, the diseases which they lived with, this study will demonstrate the extent to which sickness was a common component of the lives of the poor. It will then analyse changing patterns of the admission of particular diseases over the course of the late eighteenth and nineteenth centuries,

demonstrating that all three institutions witnessed a reduction in life-threatening conditions and an increase in minor chronic complaints. Potential reasons for this change will be discussed, including improving standards of living and increasing public awareness of dispensaries and the services they offered.

Chapter six will explore the approaches to treatment which were adopted by the dispensaries. It will consider regimen and the recommendations which dispensary medical staff made to patients regarding activities such as bathing and exercise. Analysis will then be made of the differing methods of treatment which were adopted, beginning with physical methods such as bleeding, blistering, and the application of electricity. Medicinal treatments will also be investigated. This will demonstrate not only which treatments were most commonly utilised by dispensary physicians, but also how provision under an outpatient system constrained and guided the methods which were used. By providing a contrast with the treatment models that have been addressed in the existing historiography, those which were adopted at infirmaries and within private practice, it will be suggested that dispensaries were, by necessity, more reliant on medical rather than physical methods of treatment, this being largely a result of their inability to monitor their patients effectively or to make use of treatments which required regular application by a medical practitioner.

Finally, chapter seven will examine the role of dispensary physicians in the field of public health. It will begin by exploring contemporary understanding of public health and the factors which impacted on the health of the populace in each of the districts under consideration here, including harvest failures, sanitation, and changing employment models. It will then explore the activities of individual dispensary physicians in the context of public health, activities which took place both within and outside the dispensaries. This chapter will then focus on two specific areas of dispensary activity in this regard: the adoption of smallpox inoculation and vaccination and the treatment of endemic and epidemic diseases. It will be argued that, while such activities demonstrate the interest of dispensary physicians in addressing public health concerns, much of the work which they undertook which had the greatest impact took place outside these institutions.

Chapter 1. The Local Context of Medical Poor Relief

Deceitful. Wanton. Idle. There were a range of terms which were applied to the sick poor in the second half of the eighteenth century and certainly many of them were far from medical. Categorisation of the poor, to separate those to be pitied from those not, the deserving from the undeserving, was common in published tracts, in law, and within the regulations of charitable organisations.[99] Strict rules regarding relief provision were considered necessary as, in the words of one charity, they served to exclude the 'profligate creatures… who practice every art of fiction and deceit, in order to impose upon the generous and humane'.[100] With increased urban migration in the later part of the eighteenth century, this fear of an influx of the undeserving, particularly into the larger cities, became commonplace, with selfishness and greed, rather than need or desperation, cast as primary motivating factors in perceived abuses. Tracts written by physicians, public commentators, and anonymous individuals were widespread on the subject, increasing in their ardency towards the end of the eighteenth century. In an influential 1786 pamphlet which proposed reform of the English Poor Law, the physician and clergyman Joseph Townsend separated the 'suffering objects… distinguished for industry, honesty, and sobriety' from those who embodied 'drunkenness and idleness cloathed [sic] in rags'.[101]

The core of Townsend's argument, that providing poor relief was frequently detrimental to the interests of the recipient, making them weak and unwilling to find work, is one which has since been widely critiqued by sociologists.[102] The practical impact of arguments such as this, however, was significant. Towards the end of the eighteenth century, applications for charitable support, particularly in the form of relief under the Old

[99] For further discussion in the historiography of the categorisation of the sick poor into those considered deserving and undeserving, see John Woodward, *To Do the Sick No Harm: A Study of the British Voluntary Hospital System to 1875* (London and Boston, 1974), pp.40-44; Lindsay Granshaw, 'The Hospital', in W. F. Bynum and Roy Porter (eds), *Companion Encyclopedia of the History of Medicine, Volume Two* (London and New York, 1997), pp.1185-1186.

[100] Anon., *Circular for the Society for the Relief of Destitute Sick* (Edinburgh, 1788), n.p.

[101] Joseph Townsend, *A Dissertation on the Poor Laws* (London, 1787), pp.2-7.

[102] See, for example, Stephen Monroe Tomczak, 'From Townsend and Malthus to the Poor Law Report: An Examination of the Influence of Ideas Concerning the Relationship of Public Aid and Reproduction on Policy Development, 1786-1834', *Journal of Sociology and Social Work*, 3:2 (2015), pp. 27–37.

Poor Law, increased significantly in both England and Scotland.[103] Failed harvests, changing migration patterns, and recruitment for the Napoleonic Wars all played a part in this.[104] This led, particularly in areas of southern and eastern England, to the introduction during periods of particular hardship of a policy of reduced prices and wage supplements, known as the Speenhamland system after the district with which it is most commonly associated. Exacerbated by measures such as this, debates on the role of charity took a distinctly economic as well as moral turn, with arguments that poor relief served to encourage overpopulation and thereby increase poverty.[105]

The impact of dispensaries cannot fully be assessed without first considering the support which the sick poor received from these other sources. They were, to an extent, protected from this increasingly critical approach towards systems of relief, receiving much less stigma than the able-bodied but unemployed poor. Too stark a line cannot be drawn between these groups, however, and increasingly scholarly research has identified sickness as a fundamental part of the life-cycle of the poor.[106] In these studies, sickness is not simply seen as, frequently, a by-product of pauperism, but as one of its major causes. Expensive medical treatments, a family provider unable to work, sick children or elderly relatives in need of constant care, all would take a significant financial toll on an already impoverished household. Accessing charitable relief was only one method which was used to keep afloat, of course, and considerable recent work has been done on uncovering the survival strategies of the poor, characterised as the economy of makeshifts, including the pawning of possessions, financial credit, prostitution, and theft.[107]

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[103] Anthony Brundage, *The English Poor Laws, 1700-1930* (Basingstoke and New York, 2002), p.25; Rosalind Mitchison, 'The Poor Law', in T. M. Devine and Rosalind Mitchison (eds), *People and Society in Scotland: Volume One, 1760-1830* (Edinburgh, 1988), pp.252-257.

[104] Samantha Williams, *Poverty, Gender and Life-Cycle under the English Poor Law, 1760-1834* (Woodbridge and Rochester, 2011), pp.8-10; Rosalind Mitchison, 'The Creation of the Disablement Rule in the Scottish Poor Law', in T. C. Smout (ed.), *The Search for Wealth and Stability: Essays in Economic and Social History Presented to M. W. Flinn* (London and Basingstoke, 1979), pp.200-203.

[105] Particularly relevant here are the arguments of Thomas Robert Malthus in *An Essay on the Principle of Population; Or, a View of its Past and Present Effects on Human Happiness; With an Inquiry into Our Prospects Respecting the Future Removal or Mitigation of the Evils which it Occasions* (London, 1803).

[106] See, for example, Ole Peter Grell and Andrew Cunningham, 'Health Care and Poor Relief in 18th and 19th Century Northern Europe' in Ole Peter Grell, Andrew Cunningham and Robert Jütte (eds), *Health Care and Poor Relief in 18th and 19th Century Northern Europe* (Aldershot and Burlington, 2002), pp.3-13.

[107] For more detailed discussions on the economy of makeshifts see Steven King and Alannah Tomkins (eds), *The Poor in England 1700-1850, An Economy of Makeshifts* (Manchester and New York, 2003); Jeremy Boulton, ' "It Is Extreme Necessity That Makes Me Do This": Some "Survival Strategies" of Pauper Households in London's West End During the Early Eighteenth Century', *International Review of Social History*, 45 (2000), pp.47-69.

While the sick poor may not have been excluded from charitable support on principle, there were a range of other methods of ordering and controlling provision which the poor were likely to experience when attempting to access medical relief. This chapter will consider the forms which this categorisation and exclusion took, in a system where individuals could be designated as too sick to receive support, or not sick enough. Indeed, the exact form their sickness took could also exclude them, making them too disruptive, too contagious, or too amoral. An individual's age, employment, or gender could also serve to prevent them from accessing certain charitable provision.

In considering these factors, this chapter will set the context for arguments made in the body of this thesis. It will focus on the support meted out to the sick poor by infirmaries and poor relief systems in the districts of Edinburgh, Kelso, and Newcastle. Initially, it will consider the impact which infirmary approaches to funding had upon the scope of their medical provision. Next, the analysis will turn to the admission policies of these infirmaries, considering both their geographical remits and the medical and moral criteria which were applied when assessing individuals for admission. The chapter will then continue by considering the variations in poor relief provision in the three districts under consideration here. First, approaches to, and the extent of, pension provision will be discussed and then the analysis will turn to the role of workhouses in the treatment of the sick poor. By considering not only the stated rules under which individuals could apply for relief but also the practical realities of provision, as detailed in clinical records, admission registers, and parish ledgers, this chapter will demonstrate the extent to which tightly structured admission rules were representative of genuine lived experiences. In uncovering the limitations of available provision through these methods, it will highlight the gaps which remained, laying a framework for the discussion in subsequent chapters of the role which dispensaries played in filling these gaps.

1.1 Infirmaries: the Finance of Exclusion

While Kelso did not establish its first hospital until the twentieth century, Edinburgh and Newcastle were both home to infirmaries in the eighteenth century, institutions which were founded in 1729 and 1751 respectively. These were part of a wider movement which took place across Britain during the century, in which voluntary hospitals were established by groups of charitable individuals, sometimes with the active support of local authorities. The clinician-historian Andrew Williams has given a total of 42 such institutions having been founded in England and Scotland over the course of the eighteenth century.[108] The voluntary element of these institutions relates to the fact that they were funded, in large part, by voluntary donations from individuals, parishes, and corporations, with additional revenue often supplied from other sources, such as church collections, charity theatre performances, and bequests.[109] In the case of the Edinburgh infirmary, funds were also generated by the sale of attendance tickets to medical students attached to the University of Edinburgh.[110] This last source of infirmary revenue contrasts to the situation within contemporary London hospitals which provided teaching facilities, where studies have shown that the fees of medical students were usually paid to the physicians and surgeons involved in the teaching rather than to the institution itself.[111]

Typically patients themselves would not comprise a source of profit, as eighteenth-century infirmaries were free of charge to all, or, at least, a majority of the patients they treated. The Edinburgh infirmary, however, provides an example of an institution where separate wards for privately funded patients were also established. These included a soldiers' ward, whose origins dated from the commandeering of a significant proportion of the infirmary during the course of the mid-century Jacobite rising and, from 1756, two

[108] Andrew N. Williams, 'Eighteenth-Century Child Health Care in a Northampton Infirmary: A Provincial English Hospital', *Family & Community History*, 10:2 (2007), p.153.
[109] For a discussion of funding mechanisms, see Amanda Berry, ' "Balancing the Books" Funding Provincial Hospitals in Eighteenth-Century England', *Accounting, Business & Financial History*, 7:1 (1997), pp.1-27.
[110] On the particular importance of student fees to the Edinburgh infirmary's funding, see Patricia M. Eaves Walton, 'The Early Years in the Infirmary', in *Edinburgh's Infirmary: A Symposium Arranged under the Auspices of the Scottish Society of the History of Medicine on 27th October, 1979 in the George Square Lecture Theatre, Edinburgh* (Edinburgh, 1979), pp.12-17.
[111] Toby Gelfand, ' "Invite the Philosopher, as Well as the Charitable": Hospital Teaching as Private Enterprise in Hunterian London', in W. F. Bynum and Roy Porter (eds), *William Hunter and the Eighteenth-Century Medical World* (Cambridge, New York and Melbourne, 1985) p.147.

separate servants' wards.[112] The final eighteenth-century addition to the Edinburgh infirmary's separately-funded specialist wards took place in the 1790s when two wards designated for the use of seamen of the Royal Navy were built.[113] This contrasts with the situation in other parts of Britain where the use of military contracting in this form was actually declining towards the end of the eighteenth century, in part due to the already high levels of overcrowding in infirmary wards.[114] Certainly the Newcastle infirmary appears not to have struck up similar agreements, despite its location as a riverside city. The merchant seamen there, although occasionally admitted on an individual basis to the infirmary, established, in 1747, their own Seaman's Fund as the primary method of support for their sick colleagues.[115]

The practical implications of the Edinburgh infirmary's separating patient admissions in such a fashion were significant. While the number of beds is given in one 1778 printed guide as having totalled 228 at that time, the range of wards reserved for servicemen and servants, in addition to the teaching ward (for specially selected medically interesting or unusual cases) and the two 'salivating wards' (for female venereal patients, who commonly paid for their own treatment) must be taken into consideration here (Figure 1.1). [116] In addition, in its 1749 statutes, the Edinburgh infirmary introduced another profit-making initiative, creating an additional category of patients, titled 'supernumerary patients', who were to be admitted for a fee.[117] The historian John Comrie has argued that once these specialist categories are discounted, only around 60 beds remained available for non-fee-paying patients who did not meet these specialist criteria.[118] While the findings shown in figure 1.1 suggest that this may have been an exaggeration on Comrie's part, nevertheless the establishment of these specialist wards certainly impacted on the sick poor's access to infirmary beds.

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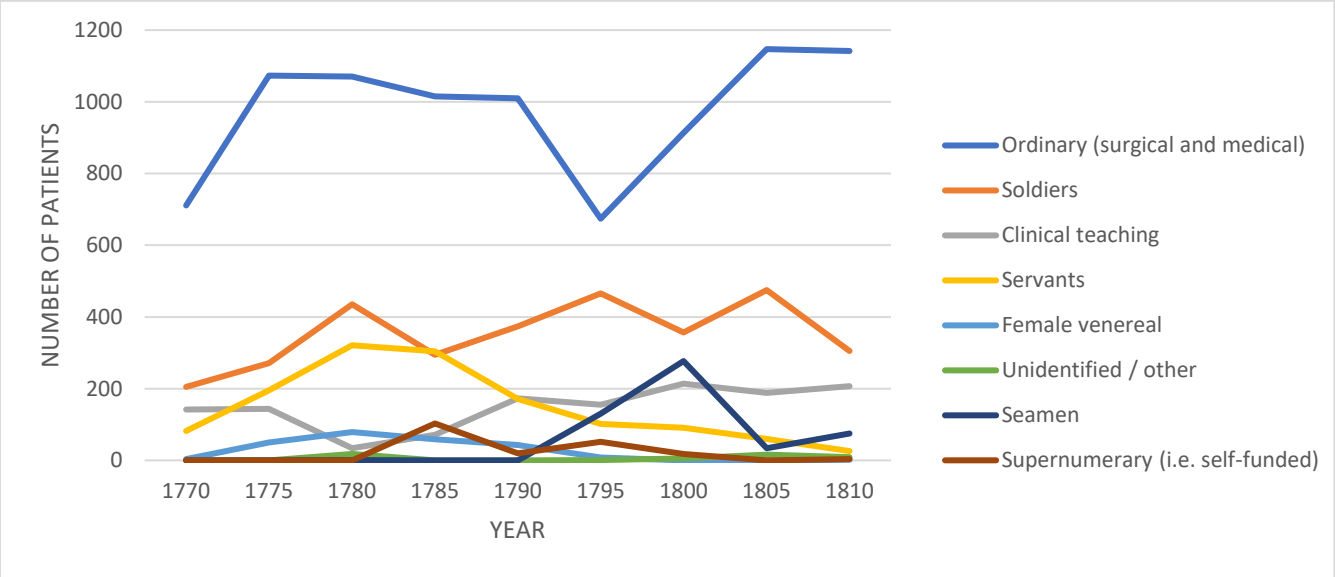
[112] *Royal Infirmary of Edinburgh Managers' Minutes,* 6 August 1744, 2 February 1756, 1 March 1756 (LHSA, LHB1/1/2-3).
[113] *Royal Infirmary of Edinburgh Managers' Minutes,* 31 January 1791, 4 June 1792 (LHB1/1/6).
[114] Guenter B. Risse, 'Britannia Rules the Seas: The Health of Seamen, Edinburgh, 1791–1800', *Journal of the History of Medicine and Allied Sciences*, 43:4 (1988), p. 427.
[115] Thomas Oliver, *A New Picture of Newcastle upon Tyne; or, An Historical and Descriptive View of the Town and County of Newcastle upon Tyne, Gateshead, and Environs, Presenting a Luminous Guide to the Stranger on all Subjects Connected with General Information, Business, or Amusement* (Newcastle, 1831), p.43.
[116] Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1778), p.10.
[117] Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1749), p.51.
[118] Comrie, *History of Scottish Medicine, Volume Two*, p.453.

Figure 1.1. Patient admissions at the Edinburgh infirmary, by admission category, 1770-1810.[119]



Source: *Royal Infirmary of Edinburgh General Patient Registers*, 1770-1810 (LHSA, LHB1/126/3-19).

Access to funding was a key aspect of this decision to allocate bed space to paying customers. Infirmaries were by far the most expensive model of charitable medical provision at this time, with high maintenance, rent, and salary costs. This, combined with increasing public concern that infirmaries served to foster dependency and encourage malingering, had a significant impact on their disposable income. Indeed, the late eighteenth century saw a reduction for both the Edinburgh and Newcastle infirmaries in the level of donations they received.[120] There are a number of respects, however, in which the two institutions differed. The Newcastle infirmary was both a smaller undertaking by comparison to its counterpart in Edinburgh (with only 73 beds listed at the turn of the century) and appears to have been more successful in managing its outgoings relative to its income.[121] While the Newcastle infirmary stated on a number of occasions during the second half of the eighteenth century that it was unable to accept new patients as all its

[119] Edinburgh infirmary admission registers do not survive for the period prior to 1770. Figures for this graph are derived from analysis of patient data in five year intervals, i.e. for 1770, 1775, 1780 etc.
[120] *Royal Infirmary of Edinburgh Treasurer's Abstracts of Accounts,* 1729-1811 (LHSA, LHB1/22/1-5); Anon., *Newcastle Infirmary Annual Reports* (Newcastle, 1751-1810).
[121] The total number of beds is not clearly stated in Newcastle infirmary records for the period and has been calculated based on totals for individual wards, therefore it is possible that it exceeds this amount, see Anon., *A Code of Statutes and Rules for the Government of the Infirmary for the Counties of Newcastle Upon Tyne, Durham, and Northumberland* (Newcastle, 1801), pp.8-10.

wards were full, the Edinburgh infirmary, by contrast, rarely filled its beds, but rather, patient admissions were regularly restricted due to a lack of available funds.[122]

The most significant difference between the funding of the two institutions, however, was the system of annual subscriptions, which was applied from the outset at Newcastle and was common across England, but was only introduced in Edinburgh in 1796.[123] Until that date the Edinburgh infirmary relied upon student fees, occasional large donations, and its own stock investments rather than regular smaller payments from a large number of individuals. The Edinburgh infirmary, unfortunately, turned to public subscription at precisely the point when interest in large-scale institutional charity was declining and, as a result, even after the introduction of subscriptions, only a small percentage of infirmary funds were raised by that method.[124] Precisely why the Edinburgh infirmary avoided public subscription for almost three quarters of a century is unclear, but its unique position as an infirmary part-financed and part-managed by the city's university may certainly have influenced its decision-making. Freedom from small donations meant greater freedom to act independently in admission and management decisions. That the Edinburgh infirmary only published its first annual report in 1802, reports which were commonly used by institutions to demonstrate their worth to potential donors and supporters, demonstrates that it was less concerned with its public perception than was the case with infirmaries elsewhere.[125]

One method of medical provision which had far fewer financial overheads and, therefore, offered the opportunity for significantly extending treatment, was outpatient care. However, while some infirmaries provided this service, it was not a prerequisite of infirmary provision, the focus being particularly on the ward-based inpatient care they provided. While the Newcastle infirmary provided outpatient treatment from its foundation, recording details of patients treated in this manner in both its annual reports and admission registers, the Edinburgh infirmary only provided a formal outpatient service between 1748 and 1754, with 'considerable abuses' of the system and resulting excessive financial

[122] *Newcastle Courant*, 28 March 1767, p.1 and 3 April 1779, p.4; *Caledonian Mercury*, 7 March 1793, p.3.
[123] Anon., *[Annual Report of the Royal Infirmary of Edinburgh]* [Edinburgh, 1802], pp.3-4.
[124] Risse, *Hospital Life in Enlightenment Scotland*, p.43.
[125] Anon., *[Annual Report of the Royal Infirmary of Edinburgh]*.

overheads later cited as having been the reason for its discontinuation.[126] Although the Edinburgh infirmary later argued that outpatient provision did continue to be provided after that date, just on a less formal basis, as no mention appears to have been made of these individuals in any surviving patient records, it is impossible to know the accuracy or extent of this in practice.[127] Moreover, as this statement was made in the context of arguments against the need for establishing a separate dispensary in the city, a subject considered in more detail in chapter two, the possibility that the infirmary was exaggerating the comprehensiveness of its treatment provision must be considered when evaluating the accuracy of this statement.

1.2 The Geography of Inclusion

It must also be borne in mind, when assessing the breadth of a provincial infirmary's patient provision, that its catchment area could be significantly larger than the boundaries of the city in which it was located. The Newcastle infirmary defined itself from its foundation as being 'of the Counties of Durham, Newcastle Upon Tyne and Northumberland', with representation on its management committee of individuals from all three districts.[128] In the case of the Edinburgh infirmary it was expressly stated that 'Diseased people of all Countries or Nations may be admitted Patients'.[129] In addition, the Edinburgh infirmary also created two 'Country Wards' in 1777 and 1778,[130] surmised by Risse to have been specifically set aside for individuals from outside the city.[131]

Furthermore, both the Newcastle and Edinburgh infirmaries emphasised that, when there was a shortage of ward beds, one method of patient selection was to prioritise those who lived the greatest distance from the infirmary.[132] In its early statutes and rules the

[126] *Royal Infirmary of Edinburgh Managers' Minutes,* 30 December 1754 (LHB1/1/3); Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1778), p.21.
[127] This point was reiterated in a number of newspapers. See *Caledonian Mercury*, 24 March 1777, p.3; *The Edinburgh Advertiser*, 28 March 1777, p.1; *Edinburgh Evening Courant*, 24 March 1777, p.1.
[128] Anon., *Statutes, Rules, and Orders for the Government of the Infirmary for the Sick and Lame Poor of the Counties of Durham, Newcastle Upon Tyne and Northumberland* (Newcastle, 1751), p.6.
[129] Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1749), p.48.
[130] These country wards are not noted in figure 1.1 because the infirmary did not record which patients were allocated to these wards when they were added to their registers.
[131] Risse, *Hospital Life in Enlightenment Scotland,* p.90.
[132] Anon., *Statutes, Rules, and Orders for the Government of the Infirmary for the Sick and Lame Poor of the Counties of Durham, Newcastle Upon Tyne and Northumberland* (Newcastle, 1751), p.17; Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1778), pp.87-88.

Newcastle infirmary even allowed for a gratuity to outpatients who resided more than ten miles from the infirmary to cover costs during their stay in Newcastle.[133] It is clear from this evidence that patient admittance was not restricted based on geographical proximity to either infirmary. Those from further afield could even be prioritised over those nearby, with one major reason for this given as 'the Encouragement of remote Subscribers'.[134] While such an approach may have served to widen the pool of potential financial backers it would also have further restricted access to an already limited resource for the needy local population.

The extent of medical provision by the Edinburgh and Newcastle infirmaries to surrounding areas is, unfortunately, not possible to track consistently over the course of the eighteenth century. In the case of the Newcastle infirmary, information on the geographical origin of patients is only available for the period from 1778 to 1788.[135] Butler's analysis of this data found that around half of the patients originated from Newcastle parishes and the rest from districts such as Chester-le-Street, Gateshead, and North Shields.[136] Regions across the north east of England, therefore, benefitted from the provision of the Newcastle infirmary. However, the foundation in the late eighteenth century of two new voluntary medical institutions in the vicinity of Newcastle may have had an impact on the infirmary's intake of patients from those districts. These institutions were the Durham infirmary, founded in 1793 (which had its origins in an earlier dispensary, dating from 1785), and the Sunderland dispensary, established in 1794.[137] Although, certainly in the case of the Durham infirmary, emphasis was made that competition with the Newcastle infirmary was not the intention, but rather that this institution would focus on the reception of accident

[133] Anon., *Statutes, Rules, and Orders for the Government of the Infirmary for the Sick and Lame Poor of the Counties of Durham, Newcastle Upon Tyne and Northumberland* (Newcastle, 1752), p.34. The extent to which this last provision was put into practice is unclear from the extant records, however, and the next surviving set of printed rules contain no equivalent statement, see Anon., *A Code of Statutes and Rules for the Government of the Infirmary for the Counties of Newcastle Upon Tyne, Durham, and Northumberland*.
[134] Anon., *Statutes, Rules, and Orders for the Government of the Infirmary for the Sick and Lame Poor of the Counties of Durham, Newcastle upon Tyne and Northumberland* (Newcastle, 1752), p.34.
[135] *Newcastle Infirmary Admission Registers*, 1778-1788 (TWA, HO.RVI/117/1-2).
[136] Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne', p.138.
[137] *Newcastle Courant*, 14 September 1793, p.2; William Hutchinson, *The History and Antiquities of the County Palatine of Durham, Volume Two* (Durham, 1823), p.676.

cases and those with acute conditions too urgent to make the journey to Newcastle for treatment.[138]

Similarly, in the Edinburgh case, medical institutions were opened in nearby cities towards the end of the eighteenth century, first the Dundee dispensary in 1782 (with the further addition of the Dundee infirmary in 1798) and the Glasgow infirmary in 1794.[139] Again, the precise impact of these on the intake of patients by the Edinburgh infirmary is unknown, with the infirmary not having consistently recorded the parish of origin of its patients. Certainly, examples can be found of funding for the infirmary being supplied by parishes outside Edinburgh into the 1780s, including from the city of Dundee, which may imply the continued use of the Edinburgh infirmary for the treatment of their sick parishioners.[140]

Institutional medical provision was largely restricted to these general infirmaries and dispensaries in the eighteenth century. While the nineteenth century is characterised by historians as having heralded a rise in institutions focused on treating specific conditions or body parts, such as eye, fistula, chest, or skin disease hospitals, in the late eighteenth century such specialisation was rare.[141] In the cases of Edinburgh and Newcastle the only specialist establishments operating at this time were institutions for the insane and lying-in hospitals for pregnant women. The former had not yet achieved the form of the large-scale dedicated asylums which would be established in both cities in the nineteenth century. During the late eighteenth and early nineteenth centuries poor sufferers in Edinburgh and Newcastle were held, respectively, in cells in the Edinburgh City Workhouse and in a private madhouse part-funded via poor relief.[142] In the case of the lying-in hospitals, these were

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[138] Thomas Dampier, *A Sermon Preached in the Cathedral Church of Durham, on the 17th of September, 1793, on the Opening of the Public Infirmary of That City* (Durham, 1793), pp.14-15.

[139] Anon., *An Account of the Dundee Infirmary, and Report of the Committee Appointed to Carry into Effect the Proposal for a Lunatic Asylum at Dundee; With a List of Contributors to the Asylum* (Dundee, 1815), p.5; *Dundee Infirmary Minute Book*, 6 March 1793 (UDA, THB1/3/1/1); Anon., *A Report of the Royal Infirmary of Glasgow, From its First Establishment 8th December 1794, till 1st January 1796, for the Year 1795* [Glasgow, 1796].

[140] See, for example, *Dundee General Kirk Session Minutes*, 9 August 1786 (DCA, CH2/1218/6).

[141] Lindsay Granshaw, ' "Fame and Fortune by Means of Bricks and Mortar": The Medical Profession and Specialist Hospitals in Britain, 1800-1948', in Lindsay Granshaw and Roy Porter (eds), *The Hospital in History* (London and New York, 1990), pp.201-216.

[142] Margaret Sorbie Thompson, 'The Mad, the Bad, and the Sad: Psychiatric Care in the Royal Edinburgh Asylum (Morningside), 1813-1894' (Ph.D. diss., Boston University, 1984), pp.21-22; William Ll. Parry-Jones, *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London and Toronto, 1972), pp.61-62.

established in Newcastle in 1760 and in Edinburgh in 1793.[143] The foundation of these hospitals was unlikely to have impacted significantly on the provision of the cities' infirmaries, however as, in the case of Newcastle, pregnant women were refused treatment and, while the Edinburgh infirmary had a lying-in ward for a time, it was the decision to close this in 1791 which prompted the foundation of the city's lying-in hospital.[144]

1.3 Moral and Medical Criteria

The decision to include or exclude pregnant women from infirmary treatment was part of a broader range of patient admission criteria which were both medical and moral in nature. The common process by which patients were admitted to infirmaries in England was one of recommendation, where, other than emergency cases, admissions were restricted to patients put forward by a subscriber to the infirmary.[145] The process at the Edinburgh infirmary, however, was somewhat different, where, while donor recommendations had priority, other individuals 'of a reputable and well known character' could also recommend patients, a ruling which would have proved particularly necessary given the low number of donors to that institution.[146]

The system of recommendation was one method of excluding those considered undeserving of public charity. Within this process of admission, however, certain additional criteria were applied, including the exclusion of those with certain medical conditions. In the case of the Newcastle infirmary, in 1751, in addition to pregnant women, the list of exclusions included the dying, children under seven and those suffering from venereal diseases, consumption, insanity or smallpox and other potentially contagious diseases.[147] These rules remained broadly consistent over the course of the eighteenth century, with only minor changes evident in the 1801 edition of the infirmary statutes.[148] While there are

[143] *Newcastle Courant*, 29 November 1760, p.3; Anon., *Laws, Orders, and Regulations, of the Edinburgh General-Lying in Hospital* (Edinburgh, 1793).
[144] Anon., *Statutes, Rules, and Orders for the Government of the Infirmary for the Sick and Lame Poor of the Counties of Durham, Newcastle Upon Tyne and Northumberland* (Newcastle, 1751), p.18; *Royal Infirmary of Edinburgh Managers' Minutes,* 3 October 1791, 7 November 1791, 5 December 1791 (LHB1/1/6).
[145] Woodward, *To Do the Sick No Harm*, pp.38-39.
[146] Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1778), p.88.
[147] Anon., *Statutes, Rules, and Orders for the Government of the Infirmary for the Sick and Lame Poor of the Counties of Durham, Newcastle Upon Tyne and Northumberland* (Newcastle, 1751), pp.18-19.
[148] Anon., *A Code of Statutes and Rules for the Government of the Infirmary for the Counties of Newcastle Upon Tyne, Durham, and Northumberland*, pp.8-9.

distinct similarities with the Edinburgh infirmary's exclusion list, there are also marked differences, such as that institution's having allowed the admission of fever and smallpox cases and, from 1749, having set aside two wards for venereal patients.[149] The acceptance of pregnant women and venereal patients is a further indication of how the Edinburgh infirmary, free as it was from the burden of appealing to the moralising philanthropy of the middling ranks, was able to make independent decisions in its selection process for admissions.[150] Restrictions on access, however, even where detailed in print, were not necessarily rigorously adhered to. A recent study, edited by Laurinda Abreu and Sally Sheard, discusses the fluidity of hospital regulations and the ability of staff to adapt, sometimes formally, sometimes on a more informal ad hoc basis, to changing local conditions.[151] The Edinburgh and Newcastle infirmaries were no exception to this and those later chapters of this thesis which investigate diagnosis and diseases consider this subject in more detail.

The structures of medical provision at the Edinburgh and Newcastle infirmaries revealed in their institutional records demonstrate that accessing treatment at these institutions in the late eighteenth and early nineteenth centuries was a complex process. Resources were increasingly stretched, with the actions of the Edinburgh infirmary demonstrating how creative attempts to increase funding could negatively impact on the provision to the sick poor. Available beds were limited, with a range of restrictive criteria applied to accessing them. It is clear that, within the generalisations made in the historiography concerning infirmary provision in this period, distinct regional differences can be identified in admission processes and the breadth of provision available to the sick poor. As a result, those in need of medical treatment and support in times of sickness could be compelled to consider other options, including the relief provided under the Old Poor Law.

[149] Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1778), pp.83-85; *Royal Infirmary of Edinburgh Managers' Minutes,* 11 February 1749 (LHB1/1/3).
[150] The treatment of venereal patients is discussed in more detail in chapter five.
[151] Laurinda Abreu and Sally Sheard, 'Introduction', in Laurinda Abreu and Sally Sheard (eds), *Hospital Life: Theory and Practice from the Medieval to the Modern* (Bern, 2013), pp.1-20.

1.4 The Poor Law Context

The Old Poor Law, at its most fundamental, provided support for those individuals who were unable to work, whether through old age or illness. Poor relief provided a vital resource for the sick poor who were unable to fund their own medicaments, lacked familial support systems sufficient to sustain them, and who were excluded from infirmaries by their stringent admissions policies. Poor relief provision in the eighteenth century, however, was not consistent across Britain. It varied between England and Scotland, between north and south in both countries and between rural and urban areas. As poor relief was commonly administered by individual parish bodies it could also vary significantly between parishes within a single city.[152] Any findings, therefore, must take into account the extent of these regional variations and historians, including Alannah Tomkins and Steven King, have questioned the extent to which broad generalisations should be attempted based upon studies which have predominantly focused on the south of England.[153]

Historians who have studied the differences in poor law legal frameworks and their practical application between England and Scotland have particularly emphasised the inclusion in many regions of England of the able-bodied poor unable to find work, with the tacit exclusion of this group from support in Scotland, where the aged and sick are seen as having been the primary focus of relief.[154] How poor relief was funded, whether by mandatory assessments of all property owners in a district or by voluntary donations, was another significant variation. In eighteenth-century Newcastle, as in much of the rest of England, assessments were carried out on landowners.[155] Records survive detailing the

[152] In the districts under consideration here, during the late eighteenth century Kelso was a single parish, while the city of Newcastle comprised four parishes, All Saints, St. John's, St. Nicholas, and St. Andrew's. Edinburgh was more fluid in its delineations, but 11 parish kirks have been identified as having been active during this period. These were: High Church, Old Church, Little Church, Old Grayfriars Church, New Town St. Andrew's Church, Tolbooth Church, Tron Church, College Church, New Grayfriars Church, Canongate Church, and St. Cuthbert's Church. See John Sinclair, *The Statistical Account of Scotland. Drawn Up from the Communications of the Ministers of the Different Parishes, Volume Six* (Edinburgh, 1793), p.563. Although Sinclair also classified parishes in the town of Leith as part of Edinburgh, they are not considered as forming part of the city of Edinburgh in this study.

[153] Steven King and Alannah Tomkins, 'Introduction', in Steven King and Alannah Tomkins (eds), *The Poor in England 1700-1850, An Economy of Makeshifts*, pp.7-9.

[154] Rosalind Mitchison, 'The Making of the Old Scottish Poor Law', *Past & Present*, 63 (1974), pp. 58-61; Larry Patriquin, 'Why Was There No 'Old Poor Law' in Scotland and Ireland?', *The Journal of Peasant Studies*, 33:2 (2006), p.225.

[155] For more detailed discussion of English poor rate assessment see Samantha Williams, *Poverty, Gender and Life-Cycle under the English Poor Law*, pp.69-100.

payments from these individuals and, while they do contain examples of absentee landowners and refusals to pay, the process was largely systematically applied.[156]

Scottish parishes in the eighteenth century are often characterised by historians as having been much less inclined to administer a mandatory levy and, where they were introduced, with rates significantly lower than those in England.[157] Reasons cited for this are varied, but often focus particularly on the lower levels of industrialisation north of the border and the continued use of payments-in-kind rather than money exchange in much of Scotland for the majority of the eighteenth century.[158] Edinburgh provides an example of this distinctly Scottish approach, where, although low levels of assessment were introduced, funds continued to be raised primarily by donations and bequests and as a result, church authorities often struggled to cover their poor relief costs.[159] Edinburgh's poor relief donations were additionally impacted in the late eighteenth century by an increasing number of secessions from the Scottish church.[160] Kelso, by contrast, like many other Scottish Border towns, was carrying out comprehensive assessments of its heritors, or landowners, by the late eighteenth century.[161] The historian Rosalind Mitchison argues that the cause for this anomaly in the Scottish approach to poor relief was depopulation, with the exodus from Border towns of younger, able-bodied individuals leaving many aged and disabled individuals without familial support.[162] Indeed, Kelso heritors themselves, in 1794, identified the high cost of relief there being due, in part, to the unwillingness of

[156] *All Saints Parish Rate Assessment Books*, 1779-1787 (TWA, 183/5-7).
[157] Mitchison, 'The Making of the Old Scottish Poor Law', p.58.
[158] Patriquin, 'Why Was There No 'Old Poor Law' in Scotland and Ireland?', pp.227-231; R. A. Cage, *The Scottish Poor Law, 1745-1845* (Edinburgh, 1981), p.87.
[159] Mention is made of the city of Edinburgh introducing assessment in 'The Reign of Charles II' in an 1839 parliamentary report, although the argument that this rate was wholly insufficient to meet local needs is made in a 1777 publication. Anon., *Report by a Committee of The General Assembly on the Management of the Poor in Scotland* (London, 1839), p.26; Anon., *A Plan for Better Providing for the Poor of the City of Edinburgh, By an Alteration of the System of Management of the Charity-Workhouse* (Edinburgh, 1777), pp.5-7.
[160] Rosalind Mitchison, *The Old Poor Law in Scotland: The Experience of Poverty, 1574-1845* (Edinburgh, 2000), pp.82-83.
[161] According to the return of Kelso's minister in 1845, a voluntary assessment was in place from 1737, with compulsory assessment introduced in 1796, see J. M. Macculloch, 'Parish of Kelso', in Society for the Benefit of the Sons and Daughters of the Clergy of the Church of Scotland (ed.), *The New Statistical Account of Scotland, Volume Three: Roxburgh, Peebles, Selkirk* (Edinburgh and London, 1845), p.347.
[162] Mitchison, *The Old Poor Law in Scotland,* p.85.

neighbouring farmers to employ aged labourers which, combined with the destruction of nearby country villages, caused an influx of the aged and needy into the town of Kelso.[163]

One method of exclusion in both England and Scotland was the system of settlement laws, by which it was necessary for an individual to prove residence in a parish for a set period of time before being applicable for relief, although these, again, varied in the time span set and extent of application.[164] For individuals who needed to travel to their parish of settlement, they could obtain a certificate to allow them free passage and, if needed, financial support from the parishes they passed through on their homeward journey. While many examples of such assistance can be found in parish records, it was also not uncommon to remove individuals from a parish against their will.[165] In practice, a method of exclusion based on both geographical origin and social status (the removal of wealthier individuals never being under consideration), speedy removal from a parish was carried out in order to prevent that parish from becoming an individual's legal residence and, therefore, responsible for their maintenance. The sick and disabled were not exempt from this treatment and cases of blind and lame individuals being removed can be found.[166]

Mitchison has argued that another significant difference between English and Scottish poor relief was the more arbitrary application of the latter, with acceptance of requests for assistance largely down to the whim of the authorities.[167] The application of this in practice can be seen in examples from the parish of St. Cuthbert's, then a suburb of Edinburgh, where individuals were refused relief even when they had been resident in the district for more than the required three years and were considered 'objects worthy' of charity.[168] Meeting these requirements, however, was not always considered sufficient. In one case a husband and wife were argued to have moved to the parish when 'so far

[163] 'Report of the Committee Appointed to Collect Information, and Report the Expediency of Erecting a Work House or Poor House in Kelso', 1794, which is found within the *Kelso Heritors' Records* (HHH, SBA/183, Box 5/1).
[164] For more detailed discussion of English settlement laws see James Stephen Taylor, 'The Impact of Pauper Settlement 1691-1834', *Past & Present*, 73 (1976), pp. 42-70, on Scottish settlement see Robert A. Cage, 'The Scottish Poor Law, 1745-1845' (Ph.D. diss., University of Glasgow, 1974), pp.20-22.
[165] For examples of removal orders, see *All Saints Parish Overseers' Accounts, Quayside Ward*, March 1798 to April 1798 (TWA, 183/90A).
[166] *All Saints Parish Monthly Accounts*, 15 February 1792 (TWA, 465/21); *All Saints Parish Overseers' Accounts, Pandon Ward*, March 1798 to April 1798 (TWA, 183/98).
[167] Rosalind Mitchison, 'North and South: The Development of the Gulf in Poor Law Practice', in R. A. Houston and I. D. Whyte (eds), *Scottish Society, 1500-1800* (Cambridge, 1989), p.219.
[168] *St. Cuthbert's Charity Workhouse Minute Book*, 6 February 1787 and 3 July 1787 (ECA, SL222/1/7).

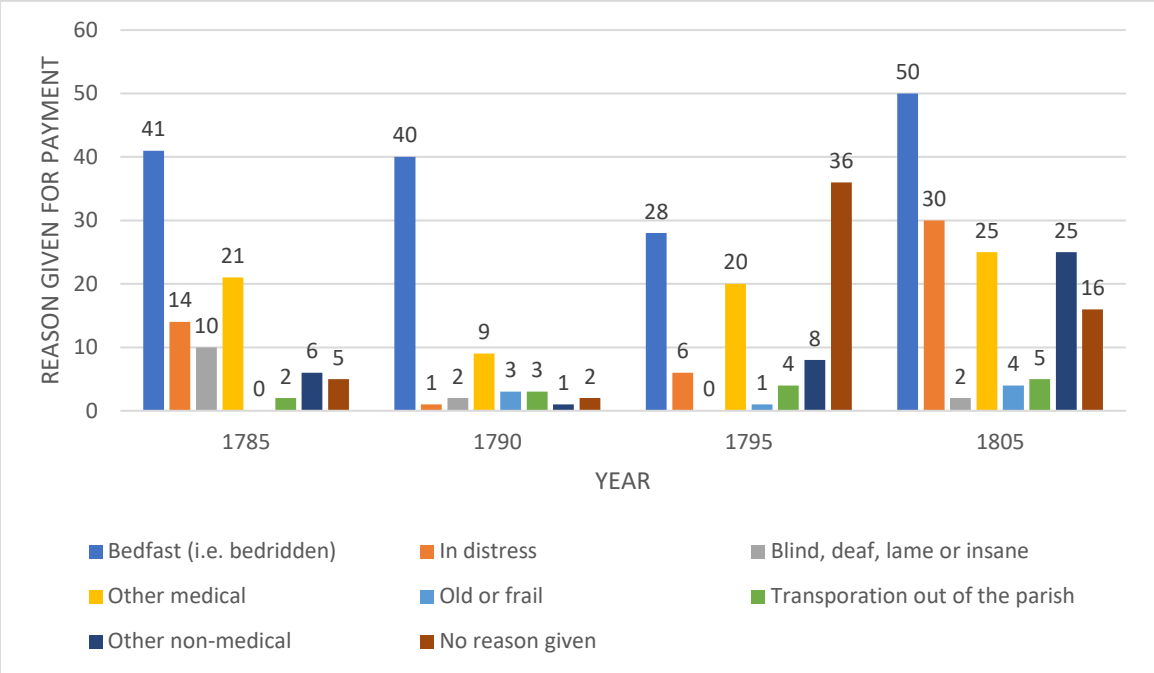
advanced in life as to be incapable of exercising any industrious employment' and, in another instance, a woman was rejected on the basis she 'never has possessd [sic] a house of her own' in the district.[169]

King has commented that the study of medical components of poor relief has been 'sadly neglected', while the historiography of other aspects of relief has burgeoned in recent years.[170] This is due, in part, to the paucity of surviving records which makes it challenging to determine to what extent the sick were recipients of relief. Regarding the districts under consideration in this study, only one of Newcastle's parishes, All Saints, has any significant surviving records for the late eighteenth century and for Kelso also, few financial records remain. In the case of Edinburgh, likewise, for many parishes, records are scanty for this period. Where records do survive, they are often notes made within sets of minutes from which meaningful statistics cannot be extracted. Figure 1.2 demonstrates the composition of pension recipients for Edinburgh's Canongate parish, for which more comprehensive records do survive.

[169] Ibid.

[170] Steven King, *Sickness, Medical Welfare and the English Poor, 1750-1834* (Manchester, 2019) [Online]. Manchester Scholarship Online. Available at: https://manchester-universitypressscholarship-com.ezproxy.is.ed.ac.uk/view/10.7228/manchester/9781526129000.001.0001/upso-9781526129000 [Accessed 11 November 2019].

Figure 1.2. Reasons given for pension payments in Edinburgh's Canongate parish, 1785-1805.[171]



Source: *Canongate Charity Workhouse Financial Records*, 1785-1805 (ECA, SL11/2/2).

The categories in figure 1.2 are primarily administrative rather than medical, with the most frequent reasons given for pension relief being 'bedfast' and 'in distress', neither of which were considered as medical diagnoses in this period. In the former case, while it is possible that some of these individuals were bedridden through age, in many others, sufferers were identified as having small children or whole families being bedridden, implying a medical rather than purely age-related aspect to their conditions. While the lack of further information makes investigation into the precise meaning of this shadowy condition of 'bedfast' impossible, the contrast with the treatment of infirmary patients is significant. While the focus of infirmaries was on a rapid turnover of treatable conditions, much of the pension relief was provided for chronic, rather than acute, conditions, with bedridden individuals, as well as the blind and lame, often remaining on the pension lists for many years.

[171] The original record details monthly payments to parish pensioners. The figures in this table were arrived at by removing repeat occurrences by the same individual within the same calendar year for the same condition, in order to only show unique cases. This has been done by using the name of the individual, the reason for their payment, and their recorded geographical location (e.g. 'Bristo Street') to identify them. Where an individual has been recorded with multiple different reasons for pension receipt, or where payments took place in a separate annual cycle, these have been recorded as separate instances. The year 1800 is omitted from this table as the detail recorded in that year is too scanty to provide comparative information. The 'other medical' category includes cases of cancer, broken limbs, jaundice, and fever.

In other cases, such as the small number of fever and smallpox cases (covered in the category of 'other medical' in figure 1.2), similar types of diagnoses can be found in infirmary and dispensary records for the same period. Indeed, too stark a line cannot be drawn between the services provided by parishes and those by medical institutions in the late eighteenth century. There was clearly a relationship between the two aspects of charitable relief, as is demonstrated by the regularity with which parishes in all three districts under consideration here paid subscriptions to nearby medical institutions in return for access to resources by their parishioners.[172] Siena, however, has questioned the extent to which this relationship was reciprocal in practice, arguing that infirmaries often resisted accepting parish paupers, as they saw them as the responsibility of the parishes, rather than themselves.[173] In the rare cases where pension recipients are recorded as having been admitted to infirmaries in Newcastle and Edinburgh, their home parish would frequently cover the costs of their transport to the institution, their clothing, or pay funds to their families to support them in their absence.[174]

Poor relief clearly played a vital role in assisting the survival of the sick and their families beyond the provision of medical aid, giving support for many of those with chronic ailments who were excluded from infirmary care. However, in only one case has a specific medical treatment been identified in the surviving pension records for the districts under consideration here, the provision, in Edinburgh in April 1798, of '6 Leeches for Mrs Anderson' for an unidentified ailment.[175] Indeed, it is likely that many of the payments made in cases of sickness were not actually for medical treatment, but simply to provide the sick with rent payments and food while they were unable to work. In this context, however, the historian Mary Fissell has argued that all payments to the sick should be categorised as health provision, regardless of how they were spent.[176] Steve Hindle, similarly, has emphasised that medical relief for the poor can only be understood in the context of the

[172] *All Saints Parish Monthly Accounts*, 17 September 1791 (465/21); *Canongate Kirk Session Collections and Distributions*, 20 November 1796 (NRS, CH2/122/163); *Kelso Parish Treasurer's Accounts*, 12 February 1779 (NRS, CH2/1173/43).
[173] Kevin Siena, 'Contagion, Exclusion, and the Unique Medical World of the Eighteenth-Century Workhouse: London Infirmaries in Their Widest Relief', in Jonathan Reinarz and Leonard Schwarz (eds), *Medicine and the Workhouse* (Rochester and Suffolk, 2013), p.24.
[174] *All Saints Parish Monthly Accounts*, August 1783 (TWA, 465/20); *Canongate Charity Workhouse Minute Book*, 6 January 1778 and 13 January 1778 (ECA, SL11/1/1/5); *All Saints Parish Monthly Accounts*, March 1789 (465/21).
[175] *Edinburgh Charity Workhouse Cashbook*, April 1798 (ECA, SL146/6/4).
[176] Mary E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol* (Cambridge, 2002), pp.97-98.

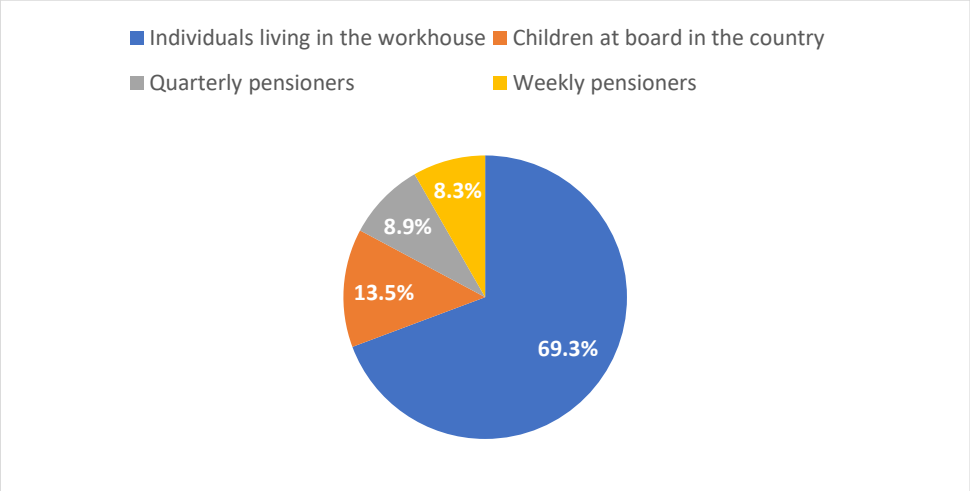
provision of mechanisms of survival for the sick.[177] Certainly eighteenth-century care-givers frequently did not differentiate between provision which was strictly medical in nature and other forms of relief for the sick, such as providing food and drink. To ignore these alternative forms of sick relief entirely would mean drawing boundaries, with hindsight, where a division would not necessarily have been recognised by contemporaries.

1.5 The Role of the Workhouse

By the mid eighteenth century, in addition to the provision of pensions, the cities of Newcastle and Edinburgh had established workhouses as a further method of poor relief. While workhouse managers were often also responsible for supplying pensions to those who resided in their own homes, focus was increasingly placed upon the provision of relief within these institutions. Workhouses, while more expensive than outdoor relief, were seen as having the distinct advantage of further separating out the deserving from the undeserving, with the shamefulness of entering a workhouse serving to dissuade those less needy from applying for relief.[178] Figure 1.3 demonstrates how, in the case of the Edinburgh Charity Workhouse, those given in-house relief totalled over four times those receiving pensions in 1774. Workhouses, however, were victims of the same vagaries of public opinion which affected other forms of institutional relief towards the end of the eighteenth century, with the argument increasingly made that this was a system which was often poorly administered and encouraged malingering at great public expense.[179]

[177] Steve Hindle, *On the Parish? The Micro-Politics of Poor Relief in Rural England c.1550-1750* (Oxford, 2006), p.266.
[178] For a more detailed description of the role of deterrence in workhouse admissions see Tim Hitchcock, 'Paupers and Preachers: The SPCK and the Parochial Workhouse Movement', in Lee Davison, Tim Hitchcock, Tim Keirn and Robert B. Shoemaker (eds), *Stilling the Grumbling Hive: The Response to Social and Economic Problems in England, 1689-1750* (New York, 1992), pp.145-166.
[179] For further discussion about changing perceptions towards workhouse relief see Joanna Innes, 'The State and the Poor: Eighteenth-Century England in European Perspective', in John Brewer and Eckhart Hellmuth (eds), *Rethinking Leviathan: The Eighteenth-Century State in Britain and Germany* (Oxford, 2004), pp.234-262.

Figure 1.3. Recipients of relief from the Edinburgh Charity Workhouse in June 1774.[180]



Source: Anon., *A Plan for Better Providing for the Poor of the City of Edinburgh, By an Alteration of the System of Management of the Charity-Workhouse* (Edinburgh, 1777).

In Kelso, while heritors held meetings in the 1790s to discuss founding a workhouse in the town, no workhouse was actually built there until the mid-nineteenth century.[181] In a report commissioned by the town's heritors to consider the value of establishing a workhouse it was decided that, while the cost of providing indoor relief was greater than the cost of supplying pensions, the value of establishing a workhouse lay in its providing a deterrence of applications from the 'lazy and indolent', reiterating the argument that, by contrast, 'no degree of shame' was felt by parishioners in applying for outdoor relief.[182] While the report concluded that, on this basis, a workhouse should be built in the district, quite why this plan was not put into action is unclear. Funding was likely to have been a major concern, although mention is made of a portion of funds being available for this purpose as a result of an Act of Parliament which placed an additional duty on the sale of beer in the district.[183] Instead, like many other smaller parishes, they appear to have contracted out this service, recording in 1796 a decision to pay the Edinburgh Charity Workhouse to receive one of their parishioners.[184]

[180] As this study relates to the provision of poor relief, categories such as beggars, criminals in the house of correction, and housekeepers have been omitted from this table.
[181] 'Report of the Committee Appointed to Collect Information, and Report the Expediency of Erecting a Work House or Poor House in Kelso', *Kelso Heritors' Records* (SBA/183, Box 5/1).
[182] Ibid.
[183] Ibid.
[184] *Kelso Heritors' Records*, 7 July 1796 (SBA/183, Box 5/1).

Edinburgh had three workhouses by the late eighteenth century; the aforementioned Edinburgh Charity Workhouse (opened in 1743), St. Cuthbert's Charity Workhouse (established 1758) and Canongate Charity Workhouse (which opened its doors in 1761).[185] In total, by the late eighteenth century Edinburgh had the capacity to accommodate over 700 individuals within the city's workhouses.[186] In all three cases the workhouses were responsible for supplying both the indoor and outdoor relief in their districts. However, while the last two provided for their own parishes, the Edinburgh Charity Workhouse had a wider remit, its foundation having been instigated by the Edinburgh Town Council and Edinburgh's General Kirk Session, with responsibility for the management of all the city's poor relief funds (excluding the suburbs of St. Cuthbert's and Canongate).[187] Edinburgh has been characterised by the historian Robert Cage as a city with particularly divergent approaches to poor relief, with Canongate and St. Cuthbert's acting in isolation from the other parishes and with little cooperation between them.[188] This is seen by Cage as having allowed individuals to take advantage of this lack of communication, in some instances applying for relief from multiple parishes simultaneously.[189]

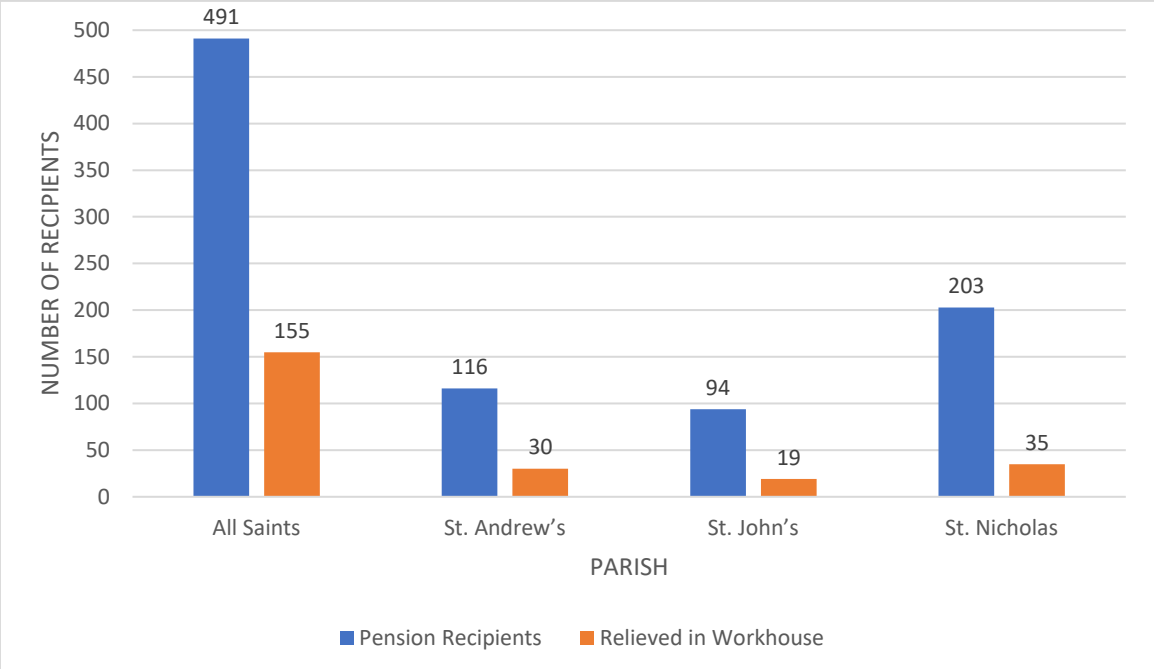
Newcastle, by contrast to Edinburgh, appears to have had a significantly lower level of workhouse provision in the late eighteenth century. In a 1777 parliamentary enquiry the city was identified as having two workhouses, one in All Saints (with a stated maximum capacity of 100) and another in St. John's (with a maximum of 26).[190] Records relating to the St. John's workhouse have not been located during this research, however, it is relevant here to consider contemporary understanding of what comprised a workhouse. With some districts listed in the enquiry with workhouse capacities as low as four, or even one, it is likely that the smaller institutions were more akin to almshouses, or even rooms in an individual's home, rather than institutions for the employment and relief of the out-of-work, sick, and elderly.[191] In relation to Newcastle's other two parishes, St. Nicholas and St. Andrew's, before 1785 these were both involved in the management of, and presumably

[185] The full title of the St. Cuthbert's was the 'St. Cuthbert's West Kirk Charity Workhouse'.
[186] Cage, 'The Scottish Poor Law, 1745-1845' (Ph.D. diss., University of Glasgow, 1974), n.p.
[187] *Edinburgh Town Council Minute Book*, 14 November 1739 (ECA, SL1/1/60).
[188] Cage, *The Scottish Poor Law, 1745-1845* (Edinburgh, 1981), p.50.
[189] Ibid.
[190] Anon., *Abstracts of the Returns Made by the Overseers of the Poor, in Pursuance of An Act Passed in the Sixteenth Year of His Present Majesty's Reign* ([London], 1777), p.135.
[191] Anon., *Abstracts of the Returns Made by the Overseers of the Poor, in Pursuance of An Act Passed in the Sixteenth Year of His Present Majesty's Reign*, p.18 and p.42.

also nominated parishioners for admittance to, the All Saints workhouse.[192] However, by the end of the eighteenth century both St. Nicholas and St. Andrews parishes had established workhouses of their own.[193]

Figure 1.4 demonstrates the number of recipients of both workhouse and outdoor relief in Newcastle in the early nineteenth century and, while there was a slight increase from the totals noted above for 1777, it is clear that the number of workhouse places remained significantly lower than was the case in Edinburgh. While the cause of this regional variation is unclear, a possible contributing factor may have been a lack of available funds on the part of the parishes of Newcastle. It is clear from surviving records that All Saints parish made extensive regular contributions from poor relief funds to the families of sailors and those of militia men, not only from Newcastle but also Northumberland, Durham, Cheshire, York, and Lincoln.[194] These payments often totalled over two thirds of all relief payments, leaving significantly diminished funds for other aspects of poor relief.[195]

Figure 1.4. Recipients of poor relief in the city of Newcastle in 1803.



Source: Anon., *Abstract of the Answers and Returns Made Pursuant to an Act, Passed in the 43d Year of His Majesty King George III* (London, 1804).

[192] *All Saints Parish Poor House Accounts*, 15 April 1777 (TWA, 595/54).
[193] Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne', p.224.
[194] *All Saints Parish Overseers' Accounts, Pandon Ward*, 1797-1808 (183/98).
[195] The Militia Act was not extended to Scotland until 1797 and so the districts of Edinburgh and Kelso were not similarly impacted. For a more detailed discussion of this subject, see Matthew McCormack, *Embodying the Militia in Georgian England* (Oxford, 2015), p.7.

The approach which workhouses took regarding the sick poor varied considerably. While each of the workhouses provided medical assistance, both in the form of nurses and of surgeons, the remit of these individuals is not always made clear. The All Saints workhouse records show that it employed four nurses to attend sick patients.[196] In the case of the Edinburgh Charity Workhouse, similarly, nurses were 'appointed to attend the Sick'.[197] In other instances some of those typified as nurses may have been wet nurses rather than acting in a capacity of tending the sick although, in the case of the Canongate workhouse, the presence of male names on staff lists suggests that at least some of those appointed had some medical or care-giving role.[198] In addition, in the case of that particular workhouse, where the actions of the surgeon are documented they usually relate to checking petitioners to ensure that those who were sick were not admitted rather than in treating them.[199]

That policies regarding assistance to the sick poor were not consistent, even across one city, is made clear by the regulations of both the Edinburgh Charity Workhouse and the St. Cuthbert's workhouse. There, the surgeons were to provide medicine for the sick of the house and those with infectious conditions, rather than being refused access, were to be separated from others until no longer contagious.[200] This therapeutic role is further demonstrated by a complaint recorded in 1786. In that year the St. Cuthbert's workhouse minutes detail claims that Mr Kerr, the surgeon at that time, was failing to attend the workhouse regularly and was refusing to give medicine to the sick poor who visited him at his home.[201] The dual role of this particular surgeon, to provide medical assistance to individuals both inside and outside the workhouse demonstrates that, at least in this instance, the parish considered medical attention to be a core part of its remit. However, the detailed inventories made of the rooms, furniture, and equipment in that workhouse from 1763 to 1777 contain no mention of medical equipment or provisions, implying, perhaps, that the treatment which was available in-house was not extensive.[202] At the All

[196] *All Saints Parish Vestry Minute Book*, 1789-1792 (TWA, 183/173).
[197] Anon., *Regulations for the Charity Workhouse or Hospital of Edinburgh* (Edinburgh, 1743), p.18.
[198] *Canongate Charity Workhouse Financial Records,* August 1782 to December 1782 (ECA, SL11/2/2).
[199] *Canongate Charity Workhouse Minute Book*, 7 December 1790 (SL11/1/1/7).
[200] Anon., *Regulations for the Charity Workhouse or Hospital of Edinburgh*, p.19; *St. Cuthbert's Parish Church Minute and Account Book of Poor Funds*, 27 May 1762 (NRS, CS96/295).
[201] *St. Cuthbert's Charity Workhouse Minute Book*, 13 June 1786 (SL222/1/7).
[202] *St. Cuthbert's Charity Workhouse Inventory*, 1763-1777 (ECA, SL222/4/1).

Saints workhouse, by contrast, not only were sick inmates provided with additional foodstuffs, but medicines were also administered, including 'mint water', a patent treatment called 'Godfrey's cordial', and 'Batemans drops'.[203]

1.6 Conclusion

This chapter has demonstrated the distinct differences in charitable medical provision between the regions under consideration here. While the town of Kelso lacked major edifices like an infirmary or workhouse, their charitable undertakings were not insignificant, based, in large part, on their geographical location as a major centre in an area which was experiencing significant depopulation in the period, with a resulting influx of elderly and otherwise needy individuals into the town of Kelso. The larger districts of Newcastle and Edinburgh, by contrast, by the mid-eighteenth century possessed large-scale institutional structures in the form of both infirmaries and workhouses. The extent of provision by these means and the way in which access to charitable relief was implemented, however, provide significant contrast.

Access to Edinburgh's infirmary was restricted, in large part, as a result of the institution's funding arrangements. The increased funding difficulties which that infirmary faced during the second half of the eighteenth century only increased the extent of these restrictions. This privately funded approach, however, did allow the Edinburgh infirmary to circumnavigate certain considerations of philanthropic propriety, with the institution able to open access to groups which might otherwise have been excluded, such as pregnant women and those suffering from venereal diseases. The Newcastle infirmary, by contrast, with its reliance on public donations, was forced to take more moral criteria into consideration, excluding a wider array of groups from treatment provision.

In addition, the focus by both the Edinburgh and Newcastle infirmaries on the importance of a rapid turnover of patients left those with long-term conditions largely excluded from infirmary care. Poor relief helped to fill this gap, often acting as a final recourse for the long-term sick and the disabled. However, poor relief was still restricted to those who were long-term residents in the district and was often meted out with significant variation, not just regionally but even within a single parish. This study has thus

[203] Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne', p.264.

demonstrated that, despite certain regional differences, in all three districts, the medical treatment of chronic cases was extremely limited and those sufferers, along with a range of other individuals who fell foul of the stringent categorisation applied, were restricted from access to the limited resources available via both infirmaries and poor relief provision.

Chapter 2. Dispensary Origins and Administration

As chapter one demonstrated, the combined administrative and financial resources of institutions such as infirmaries and workhouses fostered stability and demonstrated to the community at large the legitimacy of these bodies. This chapter will now consider the foundation and management of dispensaries. By contrast, these were usually much smaller organisations. They were smaller in the context of staffing, of financial resources, and of public visibility. This inevitably created limitations to the assistance that these dispensaries were able to provide to the sick poor. It also, however, allowed the dispensaries flexibility in their scope, their management, and their ability to work outside certain established societal norms and expectations.

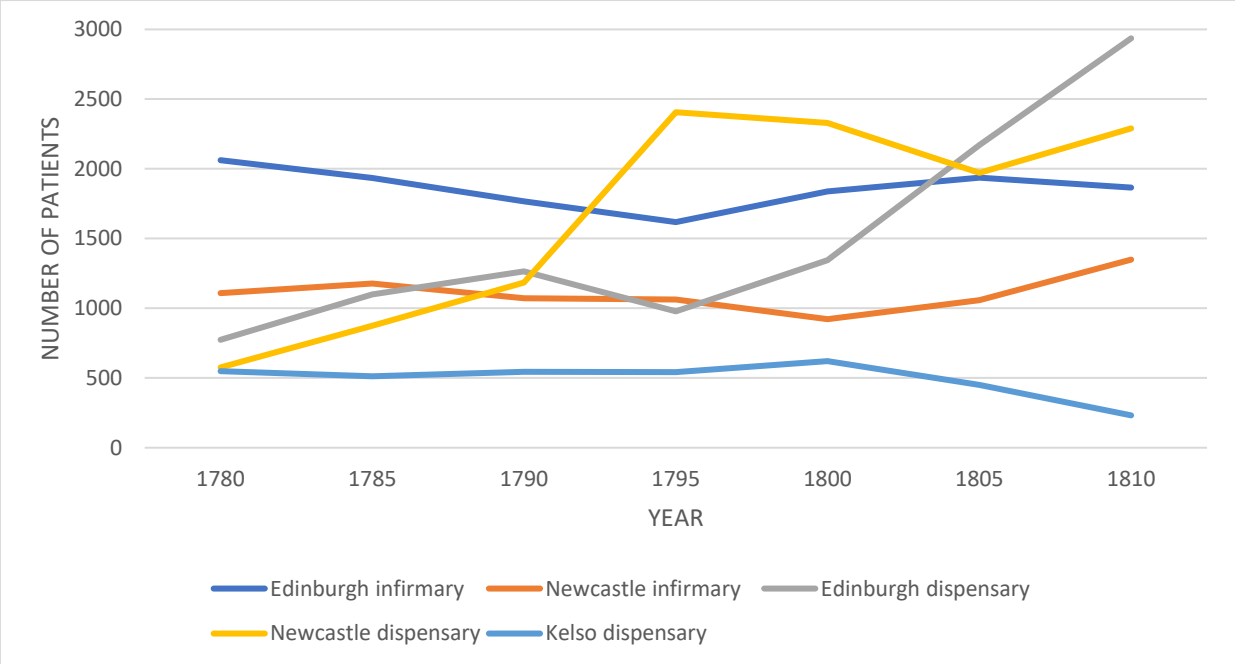
Frequently, when historians have examined eighteenth-century dispensaries, the term 'dispensary' is taken to be self-explanatory and no clear definition is provided. One feature, implicit in many studies and made explicit by some historians, including Bronwyn Croxson, was that the services provided were solely for the sick poor rather than being generally available to all.[204] A further feature identified in a number of studies is that the services provided, both in terms of advice and the supply of medication, were free of charge.[205] This notion, that the provision of a free service was key to the working of a dispensary, is one which had become embedded by the end of the eighteenth century but had not in fact always been the case. The definition of the term 'dispensary' in the *Royal English Dictionary* of 1771 detailed that 'bills are made up at a low price, for the benefit of the poor'.[206] Dispensary services, according to this definition, were cheap, but not necessarily free. Indeed, many of the earliest dispensaries, including that established by the Royal College of Physicians of London in the 1690s, did charge patients a fee for the treatments which they provided.[207]

This was, however, before the large-scale establishment of free dispensaries which took place in the late eighteenth century. The precise form which these dispensaries took

[204] Bronwyn Croxson, 'The Public and Private Faces of Eighteenth-Century London Dispensary Charity', *Medical History*, 41:2 (1997), p.127.
[205] See, for example, David Owen, *English Philanthropy, 1660-1960* (London, 1965), p.121.
[206] D. Fenning, *The Royal English Dictionary; or, A Treasury of the English Language* (London, 1771), n.p.
[207] Cecil Wall, Hector Charles Cameron and Edgar Ashworth Underwood, *A History of the Worshipful Society of Apothecaries of London: Volume One, 1617-1815* (London, New York, and Toronto, 1963), pp.125-130.

varied: some were established as an adjunct to existing infirmaries, others were established in towns where there was no infirmary (and, perhaps, where population size could not justify the founding of one), others in close proximity to, and sometimes in competition with, existing infirmary provision.[208] Indeed, the growth in such provision was so rapid that it has been estimated that by the turn of the nineteenth century 50,000 patients a year were being treated by dispensaries in London alone.[209] By that point the numbers treated at both the Edinburgh and Newcastle dispensaries had surpassed those of their infirmary counterparts (Figure 2.1).[210]

Figure 2.1. Patient admissions at the Edinburgh infirmary,[211] Newcastle infirmary,[212] Edinburgh dispensary, Newcastle dispensary, and Kelso dispensary, 1780-1810.



Sources: *Royal Infirmary of Edinburgh General Patient Registers*, 1780-1810 (LHSA, LHB1/126/3-19); Anon., *Newcastle Infirmary Annual Reports* (Newcastle, 1780-1810); *Caledonian Mercury*; Anon., *Newcastle Dispensary Annual Reports* (Newcastle, 1780-1810); Anon., *Kelso Dispensary Annual Reports* (Berwick, Kelso, and Edinburgh, 1780-1810).[213]

[208] John V. Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and its Region, 1752-1946* (Manchester and Dover, 1985), p.17.
[209] Marland, *Doncaster Dispensary*, p.15.
[210] For a more detailed discussion of Edinburgh and Newcastle infirmary and dispensary admission numbers, see chapters one and three of this thesis.
[211] Totals given for the Edinburgh infirmary include all the additional wards, discussed in chapter one, dedicated to venereal patients, seamen, soldiers etc.
[212] Totals for the Newcastle infirmary include both inpatients and outpatients. Totals are not available for 1795 for this institution so the total given for 1794 has been included in its place.
[213] The Kelso and Newcastle dispensary annual reports presented their annual totals in 12 month increments from the date of their foundation. The Kelso dispensary, therefore, because it was founded in October 1776 presented its annual totals, not from January to December of a single year, but rather from 1 October to 30

The relationship between dispensaries and infirmaries is one which has been highlighted frequently in the literature. Susan Lawrence has emphasised that dispensaries were cheaper to run than infirmaries and this, combined with the notion that by contrast with other charitable support they neither fostered dependency nor disrupted familial support systems, encouraged donations.[214] Comparing their own aims to those of their infirmary counterparts, dispensary founders often emphasised the potential negative impact of removing individuals from their families by placing them under inpatient care.[215] According to this argument, many of those individuals were not so ill as to be unable to work or care for their families. By removing them from their homes, their dependents may thereby be reduced to penury.[216] According to one charitable publication, the removal of a man's wife in such a manner could result in him spending his 'evenings in a public house, where he may form connections which may ultimately destroy his own happiness'.[217] Historians, including Croxson, have considered the impact which such public concerns surrounding dependency and the importance of encouraging productivity on the part of the sick poor had on support and funding for dispensaries.[218]

In addition, some studies have focused on the importance of the role of Quakers in the origins of the dispensary movement. The historians Robert Kilpatrick and Maisie May in particular have embodied this perspective, arguing that Dissenters were fundamental to the development and success of the movement.[219] Lawrence, by contrast, has argued against this approach, writing that the 'reforming rhetoric he [Kilpatrick] describes was ubiquitous among many social and religious groups'.[220] A more common view which includes, but is not exclusive to, Dissenters has been to emphasise the outsider nature of many of the

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September the following year. The numbers given in this graph, therefore, while comprising an entire 12 month cycle, do not cover a single calendar year.

[214] Susan C. Lawrence, *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth-Century London* (Cambridge, 1996), p.41.

[215] Anon., *Plan for Instituting a Public Dispensary at Newcastle for the Relief of the Indigent Confined to Their Own Houses by Sickness* (Newcastle, 1777), p.5; *The Scots Magazine*, January 1781, pp.1-2.

[216] Ibid.

[217] Anon., *An Account of the Benevolent Institution: With a List of the Governors Annexed* (London, 1801), p.4.

[218] Croxson, 'The Public and Private Faces of Eighteenth-Century London Dispensary Charity', pp.127-149.

[219] Robert Kilpatrick, ' "Living in the Light": Dispensaries, Philanthropy and Medical Reform in Late-Eighteenth-Century London', in Andrew Cunningham and Roger French (eds), *The Medical Enlightenment of the Eighteenth Century* (Cambridge, 1990), pp.257-264; Maisie May, 'Inoculating the Urban Poor in the Late Eighteenth Century', *British Journal for the History of Science*, 30:3 (1997), pp.299-301.

[220] Lawrence, *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth-Century London,* p.42, note 20.

eighteenth-century founders of dispensaries.[221] According to this argument, one of the major differences between dispensaries and infirmaries, beside the lack of provision of inpatient services, was that dispensaries were usually established by medical practitioners rather than by lay-people.[222] Founding a dispensary enabled practitioners who were otherwise outside the medical establishment to develop their careers and enhance their social status. The historian Toby Gelfand has emphasised the importance of the role of Scottish graduates in London in this context, their dispensary affiliations enabling them to circumnavigate the fact they were excluded from fellowship of the London College of Physicians.[223]

This chapter will add to the existing literature by seeking to uncover the continuities and differences between these established theories on eighteenth-century dispensaries and the operational models of the dispensaries which are under study in this thesis. Initially it will examine the foundation of the Edinburgh, Kelso, and Newcastle dispensaries, taking into consideration the social status of their founders, their differing levels of public support, and their relationships with other organisations in their localities. The analysis will then turn to the financing of these dispensaries, considering the impact of geographical, social, and administrative differences on the dispensary's relative economic successes. The next section will explore the varying approaches of the dispensaries to patient admissions and the support which they provided, including visiting patients in their own homes. Finally, this chapter will consider the management and staffing of the dispensaries and the outcomes which resulted from their different approaches. Overall, this chapter argues that the differing circumstances of these dispensaries origins resulted in their adopting distinctly different operational models.

[221] See, for example, Granshaw, 'The Rise of the Modern Hospital in Britain', p.206.
[222] Kilpatrick, 'Living in the Light', p.257.
[223] Gelfand, 'Invite the Philosopher, as Well as the Charitable', p.122.

2.1 Founding the Dispensaries

The argument that the eighteenth-century dispensary movement received its impetus from the endeavours of outsiders, does not only pertain to religious outsiders such as Quakers and outsiders in the context of nationality, such as Scots practising medicine in England. Also included are those whose family backgrounds did not immediately place them within the educated professional elite, for both nepotism and elitism were rife in eighteenth-century medical practice. During this period Edinburgh was viewed by many as the national, and even international, centre of medical learning.[224] It was also, arguably, the centre of medical nepotism. Family names such as Monro, Gregory, and Hope are conspicuous in their repetition amongst successive generations of professors at the University of Edinburgh.[225] The Edinburgh and Newcastle dispensary founders, Andrew Duncan and John Clark, however, certainly did not originate from within this medical elite.

Duncan was born in East Neuk, Fife, in 1744 to a father who was a local shipmaster.[226] Clark, whose father was a farmer, was born in the same year in Roxburgh in the Scottish borders.[227] Both men studied medicine at the University of Edinburgh, although Clark had a break in his studies for approximately five years caused, presumably, either by illness or a lack of sufficient funds.[228] Once this period of medical study was over both Duncan and Clark took up positions as ship's surgeon with the East India Company.[229] After travelling to a range of countries, including, for both men, a voyage to China, they returned to Scotland, Duncan in 1766 and Clark in 1772.[230]

The position of ship's surgeon, both on commercial voyages and within the Royal Navy, was a popular career path for young Scottish medical practitioners.[231] The role of

[224] David Allan, 'The Universities and the Scottish Enlightenment', in Robert Anderson, Mark Freeman and Lindsay Paterson (eds), *The Edinburgh History of Education in Scotland* (Edinburgh, 2015), pp.108-109.
[225] Helen Dingwall, 'The Importance of Being Edinburgh: The Rise and Fall of the Edinburgh Medical School in the Eighteenth Century', in Ole Peter Grell, Andrew Cunningham and Jon Arrizabalaga (eds), *Centres of Medical Excellence? Medical Travel and Education in Europe, 1500-1789* (Farnham, 2010), pp.305-320.
[226] John Chalmers, 'Andrew Duncan Senior (1744-1828): A Biographical Overview', in John Chalmers (ed.), *Andrew Duncan Senior: Physician of the Enlightenment* (Edinburgh, 2010), p.1.
[227] Fenwick, *Sketch of the Professional Life and Character of John Clark*, p.2.
[228] John Chalmers, 'Andrew Duncan Senior (1744-1828): A Biographical Overview', pp.5-8; Fenwick, *Sketch of the Professional Life and Character of John Clark*, pp.2-6.
[229] Ibid.
[230] Ibid.
[231] Sara Caputo, 'Scotland, Scottishness, British Integration and the Royal Navy, 1793–1815', *The Scottish Historical Review*, 97:1 (2018), pp.103-104.

surgeon, a broad title which commonly encompassed all forms of medical practice aboard ship, was relatively well paid for those who were only just beginning their careers.[232] It also provided opportunities for research and establishing scientific credentials. At sea, surgeons could experiment and trial new treatments on their patients, an approach which would most likely have been considered unacceptable by wealthy paying clientele back home.[233] Although there is no record of any research carried out by Duncan when overseas, Clark adopted a similar approach to many of his contemporaries, researching and publishing on the work he undertook, studying in particular detail the fever outbreaks which took place amongst his ship's crew.[234]

The similarities in Duncan and Clark's career trajectories continued over subsequent years. Like many of their peers neither man had completed their medical studies while at Edinburgh. Lisa Rosner has estimated that only 17 per cent of Edinburgh medical students achieved a full MD during this period.[235] For some, particularly those who were planning to work outside London or Edinburgh (where a medical qualification was commonly a prerequisite to practice medicine), completion of their studies was not viewed as necessary.[236] For others, both the complexity of Edinburgh's examination process and the high cost attached to graduation could prove prohibitive.[237] While both Clark and Duncan's rationales for not completing their studies at Edinburgh are unknown, we do know that both men went on to be granted MDs by the University of St. Andrews.[238] This university, alongside Aberdeen, was recognised during this period as selling qualifications to paying customers without a rigorous examination or review process, unlike the more fastidious University of Edinburgh.[239] For some, these mail-order qualifications were taken as a sign of

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[232] Iris Bruijn, *Ship's Surgeons of the Dutch East India Company: Commerce and the Progress of Medicine in the Eighteenth Century* (Leiden, 2009), pp.126-127.
[233] Ibid., pp.76-83.
[234] John Clark, *Observations on the Diseases Which Prevail in Long Voyages to Hot Countries, Particularly on Those in the East Indies and on the Same Diseases as they Appear in Great Britain, Volume One* (London, 1792).
[235] Lisa Rosner, 'Students and Apprentices: Medical Education at Edinburgh University, 1760-1810' (Ph.D. diss., John Hopkins University, 1985), p.145.
[236] A more detailed discussion of the process of licencing for physicians can be found in David Harley, ' "Bred Up in the Study of That Faculty": Licenced Physicians in North-West England, 1660-1760', *Medical History*, 38:4 (1994), pp.398-420.
[237] Rosner, 'Students and Apprentices: Medical Education at Edinburgh University', pp.154-187.
[238] John Chalmers, 'Andrew Duncan Senior (1744-1828): A Biographical Overview', pp.8-10; Fenwick, *Sketch of the Professional Life and Character of John Clark*, pp.7-8.
[239] This phenomenon has been widely commented on by historians. See, for example, Laurence Brockliss, 'Medical Education and Centres of Excellence in Eighteenth-Century Europe: Towards an Identification', in Ole Peter Grell, Andrew Cunningham and Jon Arrizabalaga (eds), *Centres of Medical Excellence? Medical Travel and*

deficiency on the part of the qualifying practitioner.[240] The possibility, however, that there was an element of social elitism in this viewpoint should not be ignored. Perhaps those who could afford the higher fees of the University of Edinburgh were viewed as more appropriate for the prestigious status of qualified physician.

Despite these impediments to their advancement, both men worked hard to establish themselves in medical circles. In 1773 Duncan founded a journal titled *Medical and Philosophical Commentaries* which, with periodic changes to both title and format, remained in print for over a hundred years.[241] That same year he also founded a medical society, the Aesculapian Club, whose aim was to forge better relationships between practicing physicians and surgeons.[242] This was only the first of many clubs and societies, both medical and non-medical, which Duncan was to found over the course of his lifetime.[243] Given his involvement in horticultural, bathing, and drinking societies, and even a society dedicated to 'sexual licence, with an emphasis on masturbation', it seems likely that his undertakings had a social as well as professional purpose.[244]

The next stage of Duncan's medical career and that which pertains directly to the foundation of the Edinburgh dispensary began in 1774. John Gregory, Professor of the Institutions of Medicine at the University of Edinburgh, had died the previous year and Duncan was nominated as his temporary replacement until a successor was found.[245] In 1776, when a final decision came to be made, there were two candidates for the position, Duncan and James Gregory.[246] Gregory was the son of the previous incumbent and,

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Education in Europe, 1500-1789 (Farnham, 2010), pp.40-41; Roger French, 'The Anatomical Tradition', in W. F. Bynum and Roy Porter (eds), *Companion Encyclopedia of the History of Medicine, Volume One* (London and New York, 1997), p.99; Lisa Rosner, *Medical Education in the Age of Improvement: Edinburgh Students and Apprentices, 1760-1826* (Edinburgh, 1991), p.15, p.17, p.24, pp.168-169.

[240] Indeed, one former student of the University of Edinburgh who failed his examinations there and instead was awarded MD by the University of St. Andrews felt so reputationally impacted by this that he wrote a lengthy text defending himself and his achievements. See Francisco Solano Constâncio, *An Appeal to the Gentlemen Studying Medicine at the University of Edinburgh* (London, 1797).

[241] Iain Chalmers, Ulrich Tröhler and John Chalmers, 'Medical and Philosophical Commentaries and its Successors', in John Chalmers (ed.), *Andrew Duncan Senior: Physician of the Enlightenment* (Edinburgh, 2010), pp.36-53.

[242] *Records of the Aesculapian Club*, 2 April 1773 (RCPE, DEP/AEC/1/1).

[243] John Chalmers, 'Medical Clubs and Societies Founded by Andrew Duncan', pp.114-132; James A. Gray, 'The Royal Medical and Medico-Chirurgical Societies', pp.134-154; Connie Byrom and John Chalmers, 'The Royal Caledonian Horticultural Society', pp.156-167; John Chalmers, 'Duncan's Non-Medical Clubs and Societies', pp.169-180, in John Chalmers (ed.), *Andrew Duncan Senior: Physician of the Enlightenment* (Edinburgh, 2010).

[244] John Chalmers, 'Duncan's Non-Medical Clubs and Societies', p.175.

[245] Rosner, *Medical Education in the Age of Improvement: Edinburgh Students and Apprentices*, p.52.

[246] Ibid.

although only 23 years of age, was appointed to the position.[247] The extent of Duncan's disappointment with this decision is made clear in his published journal where he ran an extensive article detailing what he viewed as the failures in the appointment process.[248] He argued that the appointees, including the Lord Provost, had favoured Gregory from the outset.[249] Duncan believed that nepotism was the reason that Gregory had been selected for the post rather than ability and noted that he, Duncan, had 'no powerful connection, no political interest, to aid my cause'.[250] While Duncan had been serving in this temporary position he had been granted access to the Edinburgh infirmary's teaching ward, a privilege only available to medical professors at the university. After losing his professorship, therefore, he also lost access to his charitable patients and to the teaching and research opportunities which they provided. In order to overcome this restriction Duncan began advertising private medical classes and brought in non-fee-paying patients to be used for teaching purposes.[251]

The precise date on which the Edinburgh dispensary was founded is not clear. In a printed text dating from 1777, Duncan described how he had conducted clinical lectures as part of his 'private Dispensary' during the winter academic session of 1776 to 1777.[252] This dispensary was now, in 1777, to be made public.[253] The lack of clear delineation between Duncan's private practice, individual charitable work, and the foundation of his dispensary is demonstrated by the note taking of his students at that time. An individual student's lecture notes would begin in 1775, when Duncan was lecturing at the university and the infirmary, then smoothly transition to his private medical teaching and dispensary clinical lectures without any distinction made between them.[254]

Clark, like Duncan, adopted a range of approaches to make a name for himself in medical circles. He corresponded extensively with peers in London, Manchester, and

[247] Ibid.
[248] *Medical and Philosophical Commentaries*, 4:1 (1776), pp.99-107.
[249] Ibid., pp.99-100.
[250] Ibid., p.103.
[251] Andrew Duncan, *Observations on a Proposal for Establishing at Edinburgh a Public Dispensary, for the Relief of the Poor, when Subjected to Chronical or Tedious Illnesses* (Edinburgh, 1777), pp.7-8.
[252] Ibid.
[253] Ibid.
[254] *Clinical Lectures of Andrew Duncan, Notes of Unidentified Students*, 1775-1777 (WL, MS.2233-2237).

elsewhere.[255] He also published widely, beginning with the aforementioned fever study. After initially setting up practice in Kelso, Clark moved to Newcastle in 1775 with the aim of further advancing his medical career.[256] His position as an outsider, demonstrated by the fact that he was the only registered physician in Newcastle who was not in the employment of the city's infirmary, appears to have initially inhibited his advancement.[257] Once he settled in Newcastle Clark began to develop his private practice alongside undertaking charitable work, first treating poor patients gratis in Newcastle and surrounding districts before, in 1777, declaring his intention in print to establish a dispensary.[258]

The parallels in the origin stories of the Edinburgh and Newcastle dispensaries go beyond the backgrounds of their founders. These institutions both experienced significant opposition to their establishment by local bodies, particularly the managers of the infirmaries in their respective cities. These shared difficulties did not go unnoticed by Duncan, who detailed the similarities between his own experiences in Edinburgh and the efforts of the infirmary in Newcastle to 'thwart the scheme' of founding a dispensary there.[259] The Edinburgh infirmary regarded the establishment of another charitable medical institution and, moreover, one which aimed to teach as well as practice medicine as a direct threat to its position. Medical students in Edinburgh were a profitable source of income and the infirmary was heavily reliant on these funds. The resulting disagreement played out in the public press, with statements issued on behalf of the infirmary and rebuttals by Duncan printed in the *Weekly Magazine, or Edinburgh Amusement*, *Edinburgh Evening Courant*, *The Edinburgh Advertiser,* and the *Caledonian Mercury* during the spring of 1777.[260] In Newcastle, similarly, the managers of the city's infirmary, presumably concerned in part that

[255] Clark later utilised his extensive correspondence in print as evidence of support for his undertakings. See John Clark, *A Collection of Papers Intended to Promote an Institution for the Cure and Prevention of Infectious Fevers in Newcastle and Other Populous Towns. Together With the Communications of the Most Eminent Physicians, Relative to the Safety and Importance of Annexing Fever-Wards to the Newcastle and Other Infirmaries* (Newcastle, 1802), pp.76-118, pp.173-186 and pp.233-235.
[256] Miller, 'Dr John Clark: The Forgotten Physician, 1744-1805', p.109.
[257] F. J. W. Miller, 'The Newcastle Dispensary 1777-1976', *Archaeologia Aeliana*, 5:18 (1990), p.178.
[258] Clark's patient case notes from this period were compiled into a study of fevers which was later published in 1780. This work combined case notes regarding private patients, non-fee-paying patients, and individuals who had been admitted into the Newcastle dispensary. See Clark, *Observations on Fevers, Especially Those of the Continued Type*. For details of Clark's proposal to establish a dispensary, see: Anon., *Plan for Instituting a Public Dispensary in Newcastle.*
[259] Duncan, *Observations on a Proposal for Establishing at Edinburgh a Public Dispensary*, pp.55-56.
[260] *Weekly Magazine, or Edinburgh Amusement*, 3 April 1777, pp.44-48; *Edinburgh Evening Courant*, 24 March 1777, p.1 and 29 March 1777, p.1; *The Edinburgh Advertiser*, 28 March 1777, p.1; *Supplement to The Edinburgh Advertiser*, 1 April 1777, pp.1-2; *Caledonian Mercury*, 24 March 1777, p.3.

the financial support required by the dispensary would reduce its own donations, resorted to printing their objections in local newspapers.[261]

Both men used the range of resources they had developed over their careers thus far to champion the establishment of their dispensaries: their network of medical peers, their non-medical connections and, in Duncan's case, his medical journal.[262] Indeed, Duncan used his journal not only to support his own endeavours, but also to encourage backing for dispensaries which were being established elsewhere, including in Kelso.[263] In the case of the Kelso dispensary Duncan noted with some envy the success which it experienced in swiftly garnering the support of prominent individuals, in contrast to his own initial struggles.[264]

Duncan's comments demonstrate how the model, applicable in the cases of Edinburgh and Newcastle, of the centrality of the 'outsider' physician to the foundation of eighteenth-century dispensaries was not always the case. The Kelso dispensary was established, not primarily through the work of an individual physician, but rather through the campaign work of Elizabeth Baillie, a member of the local landed gentry.[265] Baillie worked alongside a local physician, Christopher Douglas, to promote the fledgling charity to church authorities and wealthy individuals.[266] Baillie was a philanthropist who supported a range of other medical charities, including Edinburgh's Society for the Relief of the Indigent Blind.[267] Her continuing interest in medical charity is further demonstrated by her enquiries, in 1771, to the University of Edinburgh's Professor of Chemistry and Medicine William Cullen, which were forwarded to him by Douglas.[268] In his covering letter Douglas stated that 'Mrs Baillies [sic] great humanity & anxiety to releive [sic] the many distressed objects that apply to her, has induced her to inquire for cures wherever she hears of any being

[261] *Newcastle Courant*, 19 April 1777, p.4.
[262] Both men circulated their proposals to friends and colleagues to garner support before making their plans public. Duncan, *Observations on a Proposal for Establishing at Edinburgh a Public Dispensary*, p.23; Anon., *Plan for Instituting a Public Dispensary in Newcastle*, p.10.
[263] *Medical and Philosophical Commentaries*, 5:1 (1777), pp.101-104.
[264] Ibid., p.102.
[265] Christopher Douglas, 'Parish of Kelso', in John Sinclair (ed.), *The Statistical Account of Scotland. Drawn up from the Communications of the Ministers of the Different Parishes, Volume 10* (Edinburgh, 1794), p.598.
[266] Trainer, *The Doctors of Kelso*, p.12.
[267] David Johnston, *The Uncomfortable Situation of the Blind, with the Means of Relief, Represented in a Sermon, Preached in the Tron Church, Edinburgh, on Tuesday, May 15 1793, at the Request of the Society for the Relief of the Indigent Blind* (Edinburgh, 1793), p.28.
[268] Christopher Douglas, *Correspondence of William Cullen*, 19 August 1771 (RCPE, DEP/CUL/1/2/82a).

performed'.[269] Baillie subsequently became the Kelso dispensary's formal patron and was able to gain the support of the Duke of Roxburgh who, from the dispensary's opening in 1777, was listed as its president.[270]

This support, however, was not the only reason for the Kelso dispensary's initial success, so envied by Duncan. It also had the distinct advantage of being the only medical charity in the district. There was no infirmary to feel affronted by its foundation and no workhouse to absorb the charitable medical funds of local parishes. Indeed, it was highlighted in the 1777 'Plan for Establishing A Public Dispensary at Kelso For the Relief of The Indigent' that there were no funds made available by parishes in the district for an apothecary to treat the poor and they 'are thus frequently left to the public, or become a burthen to the Parish'.[271] There was, therefore, a demonstrable gap in the charitable medical provision in Kelso and its surrounds, a gap which the dispensary was able to fill without significant opposition.

2.2 Funding and Accommodation

The town of Kelso is estimated to have had a population of over 4000 in the late eighteenth century.[272] Kelso was a burgh of barony with a great deal of power and influence wielded by the town's hereditary proprietor, the Duke of Roxburgh.[273] Securing Roxburgh's support for the establishment of the town's dispensary, therefore, was a vital step in ensuring its success. The entry for Kelso in Sinclair's *Statistical Account*, dating from 1794, provides details as to the social and economic character of the district.[274] This analysis, penned by Douglas, detailed the religious composition of the town where, alongside the Church of Scotland, churches of the Episcopalians and 'Relief, Burghers, Antiburghers, Cameronians, Methodists, and Quakers' could be found, in addition to 'three Roman Catholics, and one Jew'.[275] Douglas accounted for this diversity of religious allegiances with reference to the

[269] Ibid.
[270] *Kelso Dispensary Minute Book*, 3 October 1777 (NRS, HH71/1).
[271] 'Plan for Establishing a Public Dispensary at Kelso For the Relief of the Indigent', 1777, which is found within the *Kelso Dispensary Minute Book*, 1777-1826 (HH71/1).
[272] The *Statistical Account of Scotland* gave the total population of Kelso in 1792 as 4324. Douglas, 'Parish of Kelso', p.586.
[273] Bob Harris and Charles McKean, *The Scottish Town in the Age of The Enlightenment 1740-1820* (Edinburgh, 2014), p.215.
[274] Douglas, 'Parish of Kelso', pp.576-599.
[275] Ibid., pp.585-586.

town's relatively large size and central position within the region.[276] Its position as the largest town in an otherwise sparsely populated area of small villages and crofts meant its churches, markets, and shops were utilised, not just by local residents, but by the wider region.

The distinctive characteristics of the town were reflected in the regulations adopted by its dispensary. The centrality of the church is emphasised repeatedly, where every patient admitted must be recommended by a subscriber or 'by the minister, or kirk-session of the parish where he resides'.[277] Even the opening hours of the dispensary were noted in relation to the church, for the Kelso dispensary was open to patients every Friday from 9 o'clock to noon and on Sundays 'before divine service'.[278] The role of Kelso in providing medical treatment to surrounding parishes is made clear by the number of kirk sessions, 10 in total, which subscribed to the dispensary in 1780, a figure which had increased to 13 by 1805.[279]

Alongside these kirk sessions, members of the landed gentry and local merchant and trade societies were the other primary subscribers.[280] The printed accounts of the dispensary provide evidence of the initial success it experienced in acquiring financial backing from these groups. When Kelso's financial support is contrasted with that of the Newcastle dispensary it initially appears favourable. Subscriptions to the Kelso dispensary in 1782 totalled £96 1s. 6d., while the Newcastle dispensary received £132 17s. in the same year.[281] When these sums are calculated per patient, Kelso's income totalled 5s. 6d. per head, while Newcastle's was only 4s.[282] Initially, therefore, Kelso's finances appear secure. While overall its income was lower than that of the Newcastle dispensary this is counterbalanced by its lower rate of patient admissions. This is negated, however, by Kelso's outgoing costs. As the dispensary's patient admissions declined towards the end of the eighteenth century, as demonstrated in figure 2.1, its expenditure per patient increased. This is primarily the result of overall costs such as staff salaries and property rental

[276] Ibid., p.585.
[277] Anon., *Kelso Dispensary Annual Report* (Berwick, 1780), p.6.
[278] Ibid., p.7.
[279] Ibid., pp.3-5; Anon., *Kelso Dispensary Annual Report* (Kelso, 1805), pp.5-6.
[280] Ibid.
[281] Anon., *Kelso Dispensary Annual Report* (Kelso, 1782), p.10; Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1782), p.9.
[282] Ibid.

remaining the same despite decreasing patient admission levels. In 1810 the Newcastle dispensary was paying 3s. 2d. per patient, to cover medicines, salaries, and other incidental expenses.[283] The Kelso dispensary, by contrast, in that year paid £1 1d. for each patient who was treated.[284]

Kelso's initial success, it appears, did not prove sustainable. Indeed, the dispensary's financial situation was significantly worse than these figures suggest. The dispensary's income, as detailed in its printed financial accounts, was based on the payments agreed to by its subscribers, not the actual amounts which the dispensary received.[285] Its income, in practice, would have been considerably lower as many subscribers pledged funds which were never paid. This problem was particularly pronounced in relation to kirk sessions, who often ceased payment of their fees but continued to send patients from their districts for treatment. The financial difficulties of kirk sessions in the region would have impacted on their ability to provide such funds.[286]

A range of approaches were adopted by the Kelso dispensary to resolve this issue. In its first printed annual report, dated 1778, the dispensary marked with an asterisk those parishes who sent patients to be treated but who 'have not contributed for the support of this Charitable Institution' and requested that 'such of the Subscribers as have not already paid, will pay'.[287] In 1782 the Kelso dispensary decided to draw up lists of the patients who had been treated from the non-fee-paying districts and to send these lists to the relevant kirk sessions.[288] Attempting to shame the sessions in this manner into paying their subscriptions was trialled again in 1787 but appears to have proved unsuccessful.[289] The next step which the dispensary took, in 1788, was to contact one of the worst offenders and inform him that they planned to prosecute him at the local sheriff's court.[290] This minister, in his initial response to the dispensary, had blamed his non-payment on the 'low state' of

[283] Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1810), p.13.
[284] Anon., *Kelso Dispensary Annual Report* (Kelso, 1810), p.11.
[285] The difference in wording between the two dispensaries is significant. The Kelso Dispensary's accounts detailed 'Subscriptions now due', while the Newcastle Dispensary recorded 'Subscriptions received'. Anon., *Kelso Dispensary Annual Report* (1782), p.10; Anon., *Newcastle Dispensary Annual Report* (1782), p.9.
[286] The subject of kirk session financial difficulties is discussed in more detail in chapter one.
[287] Anon., *Kelso Dispensary Annual Report* (1778), n.p.
[288] *Kelso Dispensary Minute Book*, 28 August 1782 (HH71/1).
[289] Ibid., 8 October 1787.
[290] Ibid., 1 April 1788. Although many sessions had missed payments to the dispensary, the Eccles session was a particularly extreme case, only having ever made one payment in the 10 years of the dispensary's operation. See Ibid., 8 October 1787.

the finances of his Eccles parish and promised to rectify this when he could.[291] The lack of any further mention of these court proceedings in the dispensary's minutes suggests that the proposed prosecution did not go ahead. These financial issues, however, while obviously a source of some concern to the Kelso dispensary, did not significantly impact on its ability to provide care to the sick poor as they were mitigated by the ongoing financial support of Baillie. Not only did she provide additional funds in years of dearth but Baillie also supported the dispensary's community fundraising drives.[292] This included, in the late 1780s, a project to develop new purpose-built premises for the dispensary on Roxburgh Street (Figure 2.2).[293] This new development included the addition of a limited number of inpatient beds as an adjunct to the dispensary.[294]

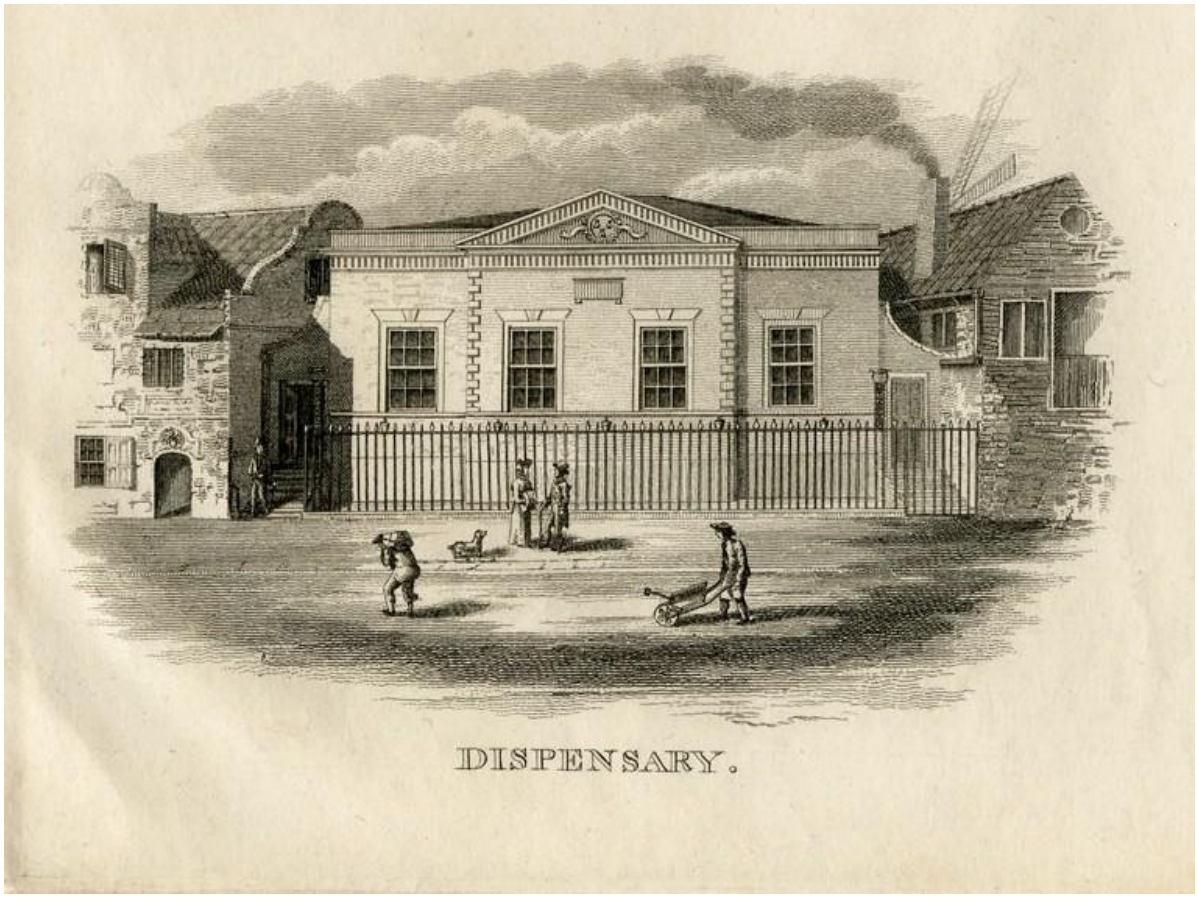
Figure 2.2. Kelso dispensary, Roxburgh Street.

Source: Author photograph, taken April 2019.

[291] Ibid., 1 July 1788.
[292] Donations from Baillie can be found in numerous annual reports. See, for example, Anon., *Kelso Dispensary Annual Report* (Kelso, 1783), p.8.
[293] *Kelso Dispensary Minute Book*, 13 October 1788 (HH71/1).
[294] Anon., *Kelso Dispensary Annual Report* (Kelso, 1790), p.3.

This was a common stage in dispensary development. Initially being established in temporary accommodation, it often took a decade or more for a dispensary to raise sufficient funds to purchase its own premises. The Newcastle dispensary, similarly, was housed in rented accommodation with 'an entry in Pilgrim Street, below the Queen's Head Inn' before, in 1790, purchasing the long-term lease of St. John's Lodge (Figure 2.3).[295] This new building comprised a meeting hall for the dispensary's governors, an apothecary shop, a patient waiting room, two consulting rooms for the physicians and surgeon, a small laboratory, and lodgings for the apothecary.[296] The addition of a room for electrifying patients, a subject which will be covered in more detail in chapter six, completed this phase of the dispensary's expansion.[297]

Figure 2.3. Newcastle dispensary, St. John's Lodge.



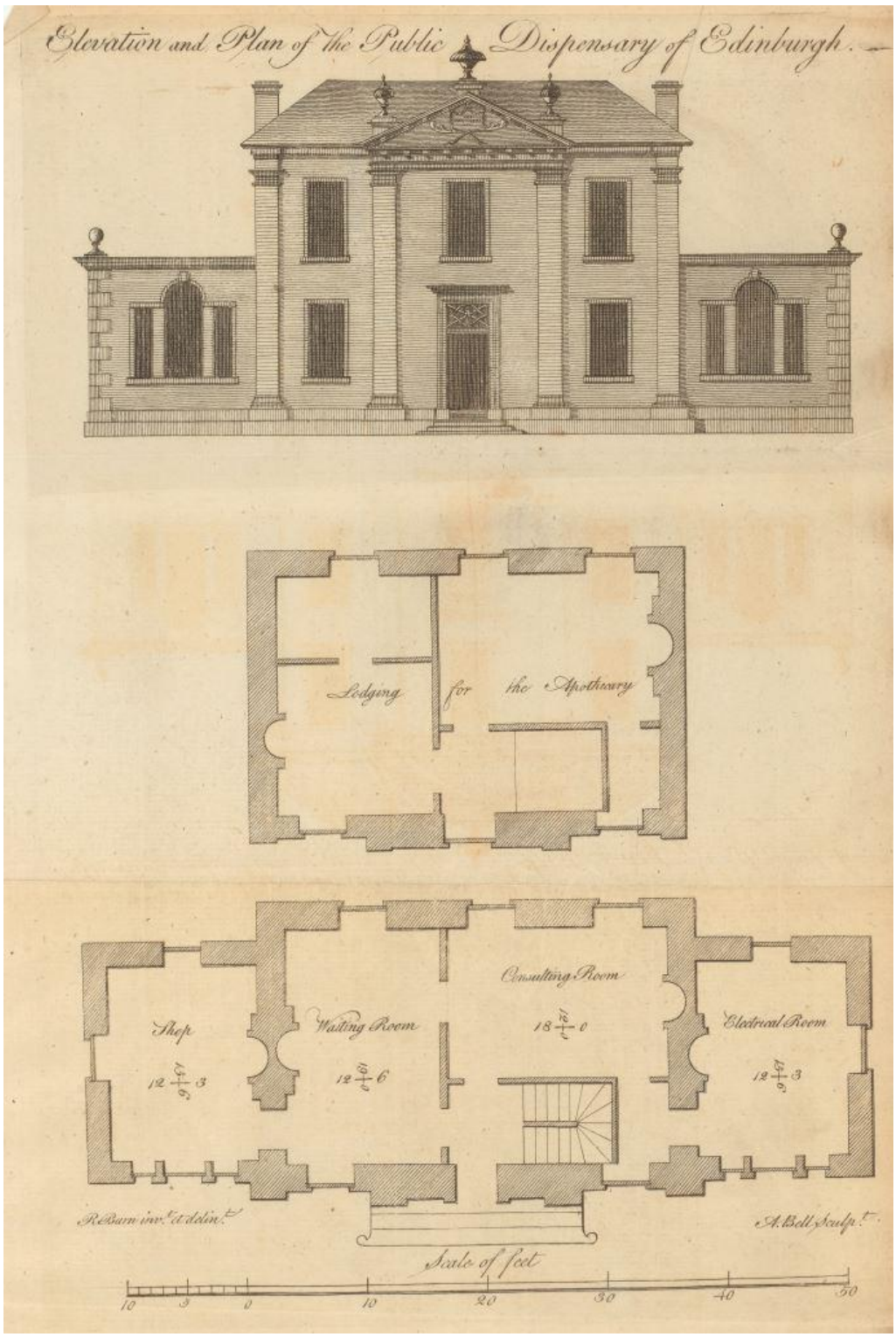
Source: *Newcastle University Library, Local Illustrations Collection* (NUL, GB186/ILL).

[295] E. Mackenzie, A *Descriptive and Historical Account of the Town and County of Newcastle-upon-Tyne, Including the Borough of Gateshead, Volume One* (Newcastle, 1827), pp.513-514.
[296] Anon., *Newcastle Dispensary Annual Report* (1790), pp.11-12.
[297] Ibid.

The Edinburgh dispensary also experienced a number of relocations in its early years. In 1777 Duncan built a property at Surgeon's Square, an area in Edinburgh's Old Town renowned for its medical schools which provided private tuition outside the walls of the city's university.[298] These schools were affiliated with the College of Surgeons of Edinburgh and operated broadly under their supervision.[299] While this supervision did not extend to closely monitoring the content of the curriculum of individual tutors, it does appear to have covered the maintenance of standards of decorum. Although lecturing to students was an accepted practice, it was deemed by the college that attendance by dispensary patients would prove a 'nuisance to the neighbourhood' and Duncan was therefore forbidden from using his premises for this purpose.[300] As a result, the Edinburgh dispensary had a number of temporary homes in its early years, including the Great Hall of the Royal College of Physicians of Edinburgh and rented rooms in College Wynd before a purpose-built dispensary was erected in 1780 on Richmond Street.[301]

[298] *Medical and Philosophical Commentaries*, 4:4 (1777), p.461.
[299] Clarendon Hyde Creswell, *The Royal College of Surgeons of Edinburgh: Historical Notes from 1505 to 1905* (London, 1926), pp.298-299. At this point in the college's history it had yet to receive its Royal Charter, and so is referred to here at the College of Surgeons of Edinburgh rather than the Royal College of Surgeons of Edinburgh.
[300] Ibid., p.61.
[301] *The Scots Magazine*, January 1781, pp.1-3.

Figure 2.4. Elevation and plan of the Edinburgh dispensary, Richmond Street.



Source: *The Scots Magazine*, January 1781, n.p.

In 1781, when the illustrations shown in figure 2.4 were printed, the main building had already been erected. This included the dispensary's consulting room and a waiting room for patients. However, the wings, containing a shop, an electrical room, and lodging for an apothecary were to be built at a later date when the dispensary's funds were sufficient.[302] There is no indication from the surviving historical records that these extensions to the dispensary were ever completed. Funding for this new building was provided by donations. Indeed, Duncan stated that this was the only purpose for these donations as all the dispensary's running costs, including the purchase of medicines, were covered by fees paid by the students who attended his clinical lectures.[303] While no detailed financial records survive to show the extent of the Edinburgh dispensary's income, a printed list of the dispensary's financial supporters demonstrates an increase in the number of individual donors, from 39 in 1778 to 52 in 1786.[304]

The progression of the Edinburgh dispensary from being the endeavour of a solitary individual to becoming an established part of Edinburgh's medical and philanthropic communities can be seen through an analysis of these donors. In the first year which the list covers, 1778, all the recorded donations were from individuals, many of whom were personal friends of Duncan.[305] By the mid-1780s, however, increasing numbers of prominent organisations feature, including the College of Surgeons, the Corporation of Shoemakers, and the Incorporation of Taylors.[306] In addition to these individual donations the dispensary was also the recipient of funds raised by theatre benefit performances and church collections.[307] By the mid-1780s the Edinburgh dispensary, similarly to its counterparts in Kelso and Newcastle, was now an accepted and supported component of its district's charitable medical relief.

[302] Ibid.
[303] Duncan, *Observations on a Proposal for Establishing at Edinburgh a Public Dispensary*, pp.28-54.
[304] Anon., *List of the Contributors to the Public Dispensary of Edinburgh* (Edinburgh, 1785), pp.3-16.
[305] Ibid., pp.3-4.
[306] Ibid., pp.12-15.
[307] For theatre benefit performances, see *Caledonian Mercury*, 27 April 1782, p.1; *Caledonian Mercury*, 14 May 1791, p.1. For mention of church collections, see *Caledonian Mercury*, 29 February 1796, p.3; *Caledonian Mercury*, 11 May 1799, p.3.

2.3 Patient Admissions and Medical Provision

Subtle differences in the ways in which the dispensaries referred to their financial incomes demonstrate a wide divergence in dispensary practices. In their regulations the Kelso and Newcastle dispensaries described their funders as 'subscribers'.[308] This approach follows the model established by charitable infirmaries whereby subscribers were permitted to recommend a set number of patients for admission relative to the level of their donation. According to the early regulations of both the Kelso and Newcastle dispensaries, patient admission was to be by 'subscriber recommendation' only; sick individuals who did not present the appropriate paperwork were not to be treated.[309] The Edinburgh dispensary, by contrast, more commonly used the term 'contributors' to refer to its financial supporters.[310] While those who pledged funds could recommend patients and those patients would be treated 'in preference to all others', admission was not restricted to such individuals.[311] The reason for this more open admissions policy is unclear. Perhaps the Edinburgh dispensary simply did not have enough subscribers in its early years to enable the use of the subscription-only model of admission. It is also possible that the distinctive aims of this institution, to provide clinical cases for medical teaching as well as to treat the sick poor, necessitated an admission process which allowed the dispensary's physicians the freedom to select patients who possessed an interesting array of medical complaints.

Regardless of these initial distinctions, all three dispensaries revised their admissions criteria over subsequent decades. The first to do so was the Kelso dispensary. Indeed, that dispensary's earliest printed admission records belie their supposedly restrictive regulations by using the category of 'strangers' to identify those who had been admitted without recommendation.[312] Although only ever comprising between 3 and 6 per cent of the dispensary's admissions each year, the inclusion of strangers demonstrates the difficulty, in practice, of applying such rigid rules.[313] It is likely that the emphasis which the Kelso

[308] Anon., *Kelso Dispensary Annual Report* (1782), p.4; Anon., *Newcastle Dispensary Annual Report* (1782), p.7.
[309] Ibid. While the Kelso dispensary allowed admission on the recommendation of ministers and kirk sessions, it is clear from the discussion earlier in this chapter that the payment of a subscription fee was also expected from these groups.
[310] Anon., *List of the Contributors to the Public Dispensary of Edinburgh.*
[311] Anon., *[List of Regulations of the Public Dispensary of Edinburgh]*, p.3.
[312] Anon., *Kelso Dispensary Annual Report* (1778), n.p.
[313] *Kelso Dispensary Annual Reports* (Berwick, Kelso, and Edinburgh, 1778-1810). In the dispensary's patient registers the term 'stranger' was added to the column where the names of subscribers were recorded, to

dispensary continued to place upon these rules, in spite of such exceptions, was an attempt to ensure the continued financial support of their subscribers.

The Edinburgh dispensary, despite the increase in its donations, appears to also have experienced financial difficulties which impacted on its admissions processes. The dispensary's patient numbers, which were included in its annual reports and published annually in the press, demonstrate a steady increase in admissions between its foundation and 1783.[314] During the following decade, however, admissions slowed and began to decline, before starting to increase again towards the close of the century (Figure 2.1). According to one newspaper article, this temporary decline was the result of insufficient funding which forced the dispensary to restrict treatment to only those patients who were recommended by one of its contributors.[315] This was later widened to also include patients recommended by their clergyman or an elder of their district, but the Edinburgh dispensary continued for the rest of the eighteenth century to maintain a level of restriction on access to its medical services.[316]

The Newcastle dispensary, as a reflection of its success in increasing its subscription levels, followed the opposite course to that of the Edinburgh dispensary, expanding rather than restricting access to its services. From 1790 the Newcastle dispensary began to accept patients without recommendations and the number of additional patients treated as a result of this change was significant.[317] In 1798, of the 2479 patients seen by the dispensary, 1075 of those were individuals without a recommendation.[318] By widening its admissions in this way the Newcastle dispensary not only increased the overall number of patients treated but also enabled provision for a whole new demographic of patients. This revised admissions process, which will be discussed in more detail in chapter three, removed the weighting which subscription-only care often had in favour of the admission of working-age males. While previously subscribers, whether landed gentry, businessmen, or medical

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denote that they had been admitted without recommendation. See, for example, Christian Steuart, *Kelso Dispensary Patient Register*, April 1779 (NRS, HH71/7).

[314] The dispensary's admissions increased from 222 in its first year to 1939 in 1783. Andrew Duncan, *A General View of the Effects of the Dispensary at Edinburgh. During the First Year of that Charitable Establishment* (Edinburgh, 1777), pp.7-15; *Caledonian Mercury*, 9 February 1784, p.1.

[315] *Caledonian Mercury*, 9 February 1784, p.1.

[316] See, for example, the *Caledonian Mercury*, 24 January 1793, p.1.

[317] Anon., *Newcastle Dispensary Annual Report* (1790), p.21.

[318] Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1798), n.p.

individuals, had been more likely to recommend men for admission, the removal of this barrier increased access to charitable medical relief for women, children, and the elderly.

The Newcastle dispensary's increased funding also allowed it to expand its home visiting programme in the 1790s to include the nearby town of Gateshead.[319] This service, established by the dispensary at its foundation, had divided Newcastle into districts, with each of the dispensary's physicians being allocated responsibility for patients within one of these districts.[320] The Kelso dispensary, although not employing such a structured approach as its counterpart in Newcastle, also provided a home visiting service to those individuals whose condition prevented them from attending at the dispensary's premises.[321] The method of home visiting which the Kelso dispensary adopted was reviewed and adapted over the course of the eighteenth century. The initial process, whereby the dispensary's surgeons were paid a flat rate for each of their 'rides', was criticised by the dispensary's committee for its excessive expense.[322] As a result, this was revised by the end of the century so that payment was made per mile, not per trip.[323]

Home visiting proved most contentious in the context of the Edinburgh dispensary. At the point of the dispensary's foundation Duncan had decided against providing this service. 'In place of visiting them at their houses', he stated, 'they shall visit us at the place of lecturing'.[324] The need to provide clinical teaching to the dispensary's students once again appears to have been a significant factor in determining the treatments which were provided. The precise nature of the Edinburgh dispensary staff's role in the provision of home visits, however, was more complex. The scholars Mathew Kaufman and Henry Cockburn, the latter writing in the nineteenth century, noted that the dispensary's staff never carried out visits to the homes of its patients.[325] Others, including Richard Scott and

[319] Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1797), pp.7-8.
[320] Anon., *Plan of the Newcastle Dispensary. Instituted October, 1777* (Newcastle, 1777), p.11; Anon., *An Account of the Newcastle Dispensary, for the Relief of the Poor, From Its Commencement in 1777, to Michaelmas 1789* (Newcastle, 1789), p.10.
[321] 'Plan for Establishing A Public Dispensary at Kelso For the Relief of The Indigent', *Kelso Dispensary Minute Book* (HH71/1).
[322] *Kelso Dispensary Minute Book,* 13 October 1788 (HH71/1).
[323] Ibid.
[324] Andrew Duncan, *An Address to the Students of Medicine at Edinburgh, Introductory to a Course of Lectures on the Theory and Practice of Physic. Delivered 1st November 1776* (Edinburgh, 1776), p.25.
[325] Kaufman, 'Edinburgh's Royal Public Dispensary', pp.65-66; Henry Cockburn, *Memorials of His Time* (New York, 1856), p.269.

David Hamilton, have argued that visiting patients in their homes was an important component of the Edinburgh dispensary's medical provision.[326]

The reality appears to lie somewhere between these two positions. There was certainly no standardised visiting service and no mention of home visiting is made in the dispensary's rules and regulations. On occasion, however, visits were certainly carried out. Duncan noted in 1776 that when William McNab, a dispensary patient who was suffering from an unidentified feverish complaint, ceased attending, Duncan 'visited him at his fathers house'.[327] In another case Duncan wished to visit a patient at his home but was unable to do so because he had 'not been able to learn where he lodges'.[328] The inability to locate the residences of patients demonstrates that the dispensary's approach to home visiting was far from systematic. Addresses were not recorded at the point of admission and visits do not appear to have been arranged with patients in advance. Nonetheless, the willingness of Duncan to carry out such visits when deemed necessary is clear. Given this, Cockburn and Kaufman's assessments should be examined more closely. In his writing, Cockburn demonstrated a generally negative opinion of Duncan and his work, describing Duncan's 'talk [as] always wearisome', much of his writing as 'very foolish', and the man himself as 'so benevolent and so simple'.[329] Kaufman uses Cockburn's assessment as part of the basis of his own research and appears to broadly share his perspective.[330] Cockburn and Kaufman also agree in one other significant regard, that Duncan's charitable offering was inferior to that of one of his peers, William Pulteney Alison.[331]

Alison was a local physician and an associate of Duncan's.[332] From the 1820s to the 1850s Alison lectured at the University of Edinburgh and, in the 1830s, he served as president of the Royal College of Physicians of Edinburgh.[333] Most pertinent to this study, in 1815 Alison co-founded Edinburgh's New Town dispensary.[334] This charity, which continued

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[326] Richard Scott, 'Edinburgh and General Practice', in Gordon McLachlan (ed.), *Medical Education and Medical Care: A Scottish-American Symposium* (London, 1977), p.60; David Hamilton, *The Healers: A History of Medicine in Scotland* (Edinburgh, 1981), p.107.
[327] *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (RCPE, DEP/DUA/1/12), p.157.
[328] Forbes Richardson, *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/13), p.108.
[329] Cockburn, *Memorials of His Time*, p.270.
[330] Kaufman, 'Edinburgh's Royal Public Dispensary', pp.65-66.
[331] Ibid., pp.63-66; Cockburn, *Memorials of His Time*, pp.268-271.
[332] Christopher Hamlin, 'William Pulteney Alison, the Scottish Philosophy, and the Making of a Political Medicine', *Journal of the History of Medicine and Allied Sciences*, 61:2 (2006), pp.152-153.
[333] Ibid.
[334] Ibid., p.155.

to operate into the twentieth century, was the first real rival to Duncan's dispensary. The competition between the two charitable bodies was clear from the outset and when word of Alison's plans reached the managers of the older dispensary they quickly proposed the establishment of their own dispensary in the city's New Town with the explicit intention of undermining the endeavours of their new rival.[335] This aim was carried out with the establishment of separate branches of the older dispensary, first in 1815 in the New Town hall of the Royal College of Physicians of Edinburgh and then in the district of Leith in 1816.[336] The initial opposition which Alison's dispensary received came not only from the Old Town dispensary but also from the city's infirmary and lying-in hospital.[337] Indeed, a printed statement by the New Town dispensary referenced the similarity between their own difficulties and the opposition which Duncan's dispensary had experienced in 1776 and argued for its own usefulness in much the same way that Duncan had forty years earlier.[338]

In this statement the New Town dispensary also used the perceived failings in the approaches of the older dispensary as a tool to demonstrate the philanthropic value of its own work, describing its own medical provision as having many 'superior advantages'.[339] This included, unlike Duncan's dispensary, a structured approach to visiting patients in their own homes.[340] It also noted other deficiencies in the older dispensary's scope, including its limited opening hours.[341] This is another critique which has since been repeated by various historians.[342] While it has a source in Duncan's own early printed regulations, which stated that patients were only treated on Tuesdays and Fridays, it does not appear to be borne out by the manuscript records of that dispensary.[343] An analysis of the dates in the dispensary's patient case notes demonstrates that treatment often took place six days a week, with only

[335] *Letter from John Waugh to James Hamilton, President of the Royal College of Physicians of Edinburgh, Proposing to Establish a Branch of the Public Dispensary in the New Town*, 19 June 1815 (RCPE, RCP/COL/3/1/250).
[336] *Royal College of Physicians of Edinburgh Meeting Minutes*, 21 June 1815 (RCPE, RCP/COL/2/1/1); *Caledonian Mercury,* 3 May 1817, p.4.
[337] Anon., *Statement Regarding the New Town Dispensary by the Medical Men Conducting that Institution* (Edinburgh, 1816), pp.37-44.
[338] Ibid., p.26.
[339] Ibid., p.5.
[340] Ibid., p.19.
[341] Ibid.
[342] See, for example, Morrice McCrae, *Physicians and Society: A Social History of the Royal College of Physicians of Edinburgh* (Edinburgh, 2007), p.135; Anand C. Chitnis, 'Medical Education in Edinburgh, 1790–1826, and Some Victorian Social Consequences'*, Medical History,* 17:2 (1973), p.179.
[343] Anon., *[List of Regulations of the Public Dispensary of Edinburgh]*, p.3.

Sundays not featuring.[344] Whether Alison was aware of this discrepancy between the dispensary's early printed regulations and its activities over subsequent decades is unclear. He was, however, able to use these early regulations to critique his rival and therefore present his own newly-founded dispensary in a distinctly positive light and subsequently his arguments have been adopted, somewhat uncritically, by some historians.

2.4 Dispensary Management

The Edinburgh dispensary was particularly susceptible to criticism from individuals such as Alison because it became viewed, both by contemporaries and historians, as the work of a single man, Andrew Duncan. Its failings were his failings and his competitors were its competitors. Duncan ensured, through his published patient case studies, the dispensary's annual reports, and his journal, that his name was clearly linked in the minds of the public with the work of the Edinburgh dispensary. This very visible association between one man and the dispensary they founded, or co-founded, was not always the case. Clark, although integral to the establishment of the Newcastle dispensary, did not push himself to the forefront in the same manner as Duncan. Unlike Duncan, Clark did not identify himself as the author of his dispensary's annual reports.[345] Instead, these reports emphasised the collaborative nature of the Newcastle dispensary, including the contributions of its managers and the range of medical staff who worked there. Indeed, in the dispensary's first report Clark placed himself at the bottom of the list of attending physicians.[346] These printed annual reports were a key element of the publicity and fundraising endeavours of dispensaries and they followed a similar model in Newcastle and Kelso to those of dispensaries and infirmaries elsewhere in Britain. They had a clear promotional purpose, detailing the breadth of the dispensary's medical undertakings. They also, in the cases of Kelso and Newcastle, included financial information, both their income and expenses and the contributions of their subscribers.

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[344] *Practical Observations in Medicine by Andrew Duncan*, 1776-1790 (DEP/DUA/1/11-47).
[345] The first annual report of the Edinburgh dispensary contained a lengthy introduction authored by Duncan. Duncan, *A General View of the Effects of the Dispensary at Edinburgh. During the First Year of that Charitable Establishment*, pp.3-5.
[346] Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1778), p.34.

The Newcastle dispensary's reports also contained extensive updates relating to subjects such as smallpox inoculation and outbreaks of infectious diseases.[347] This emphasis on the medical undertakings of the dispensary implies the guiding hand of Clark rather than the dispensary's lay management in the formulation of these reports. Indeed, Clark repeatedly emphasised the importance of such reports in the advancement of medical science.[348] In 1778 the dispensary's annual report noted that the recording of such information would ensure that 'The diseases of individuals will be better understood, and treated with more effect; and the records of the Dispensary will contain an account of the reigning diseases, and ascertain the most effectual methods of cure. Thus a lasting advantage will accrue to the public from this charity, the chief object of which was the relief of distressed individuals'.[349] The Edinburgh dispensary's reports, however, did not even contain the basic level of detail which Clark decried as insufficient. For example, no details of its income or expenditure were provided. From the eighteenth century only the Edinburgh dispensary's first two annual reports, from 1777 and 1778, appear to have survived. It is, therefore, unknown whether over the course of the dispensary's operation more information began to be included. Whether later reports were even printed and circulated is unclear, but we do know that they existed in some form as newspaper articles can be found stating that they were presented at the dispensary's annual meetings.[350]

These annual meetings and the regulations which underpinned them followed a similar model at all three dispensaries. This approach, common to many dispensaries established across Britain in the late eighteenth century, had its origins in the operational procedures of the infirmaries which had been founded earlier in the century. The precise structure which was adopted by these newer dispensaries, however, was commonly based on that of one of Britain's first public dispensaries, the General Dispensary in London, which was founded in 1770.[351] This charity was viewed by many as a model institution to emulate. Indeed, both Duncan and Clark referenced in print the influence which that dispensary's work had on the formulation of the regulations of their own dispensaries.[352] Under this

[347] Ibid., pp.25-29; Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1784), pp.8-9.
[348] Clark, *Observations on Fevers, Especially Those of the Continued Type*, pp. 369-385.
[349] Anon., *Newcastle Dispensary Annual Report* (1778), p.31.
[350] See, for example, the *Caledonian Mercury*, 24 January 1788, p.1.
[351] Loudon, 'The Origins and Growth of the Dispensary Movement in England', pp.323-324.
[352] Duncan, *Observations on a Proposal for Establishing at Edinburgh a Public Dispensary,* pp.6-8; Anon., *Newcastle Dispensary Annual Report* (1778), pp.7-8.

model, attendance at annual meetings or, in Newcastle's case, biannual meetings, was open to all financial donors as well as dispensary medical staff.[353] The purpose of these meetings was to review the regulations, patient admissions, and finances of the dispensary.[354] This approach, which gave benefactors the opportunity for oversight of the dispensary's administration, was a significant component in encouraging further donations and ensuring ongoing support. By contrast, the Dispensary for the Infant Poor, established in London in 1769, did not accede to the demands of its subscribers for greater control over the regulation of patient admissions.[355] According to Bronwyn Croxson, its subsequent financial difficulties and its closure after only 14 years of operation were a direct result of this failure to accommodate the wishes of its subscribers.[356]

In the cases of Kelso and Newcastle, further attempts were made to engage subscribers in the running of the dispensaries beyond the basic model of these meetings. The Kelso dispensary held additional quarterly meetings of smaller groups, while the Newcastle dispensary also held monthly meetings, attended by the medical staff and lay individuals.[357] In the case of the Newcastle dispensary, this management structure appears to have been less functional in practice than it would initially appear from inspection of the dispensary's printed regulations. For in 1802 the Newcastle dispensary's monthly meetings were noted to have 'fallen into disuse'.[358] Even those elected to specific management positions often did not attend dispensary meetings. The management structure at Kelso, for example, which remained consistent over the period under study in this thesis, was comprised of a president and four vice presidents.[359] The role of president was essentially a figurehead position and as such did not attend meetings. The Newcastle dispensary initially had a similar management structure to that of its counterpart in Kelso, with a single president and three vice presidents.[360] This approach was revised in 1785 when the new

[353] Anon., *A General View of the Effects of the Dispensary at Edinburgh. During the Second Year of That Charitable Establishment* (Edinburgh, 1779), p.6; Anon., *Kelso Dispensary Annual Report* (1780), p.6; Anon., *Newcastle Dispensary Annual Report* (1790), p.16.
[354] Ibid.
[355] Croxson, 'The Public and Private Faces of Eighteenth-Century London Dispensary Charity', p.129.
[356] Ibid.
[357] Anon., *Kelso Dispensary Annual Report* (Kelso, 1789), p.6; Anon., *Newcastle Dispensary Annual Report* (1790), p.16.
[358] Anon., *Proceedings of the Committee for Increasing the Usefulness of the Dispensary, at Newcastle Upon Tyne* (Newcastle, 1802), p.3.
[359] Anon., *Kelso Dispensary Annual Report* (1780), p.7.
[360] Anon., *Newcastle Dispensary Annual Report* (1778), p.33.

position of patron was introduced, which effectively replaced that of the president, with the Duke of Northumberland agreeing to undertake this more elevated post.[361] Five presidents were also appointed that year, in addition to four vice presidents.[362] The reason for this structural change is not detailed, but it is possible that the agreement of the Duke of Northumberland to sit on the management committee may have been conditional on his role being purely titular, with no involvement in the operational work of the dispensary.

The Edinburgh dispensary, in line with many of the other aspects of its administration, adopted a far less structured approach to management than either the Kelso or Newcastle dispensaries. The Edinburgh dispensary's 1778 annual report listed eight managers, with no breakdown of these into roles such as president or vice president.[363] The initial plans of the dispensary, dating from 1777, had been more comprehensive, proposing the appointment of a president, two vice presidents, a treasurer, a secretary, and six directors.[364] Perhaps the dispensary's initial difficulty in attracting public support was the reason for its subsequent implementation of a less structured management model.

At all three dispensaries these managers were, in theory, given significant oversight over funding and regulations.[365] This included control over decisions relating to the appointment of medical staff.[366] The Newcastle dispensary's regulations detailed that managers would regularly inspect the dispensary and examine its apothecary's bills.[367] As only the minutes from the Kelso dispensary survive, we do not know how often these theoretical responsibilities were actually enacted at either Edinburgh or Newcastle. Certainly at Kelso the management committee appears to have played an active part in the running of the dispensary, carrying out regular inspections of the dispensary's surgical instruments and reviewing its financial expenditure in detail.[368]

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[361] Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1785), p.2.
[362] Ibid.
[363] Anon., *A General View of the Effects of the Dispensary at Edinburgh. During the Second Year of That Charitable Establishment*, p.4.
[364] Duncan, *Observations on a Proposal for Establishing at Edinburgh a Public Dispensary*, p.9.
[365] Ibid.; Anon., *Newcastle Dispensary Annual Report* (1778), pp.15-16; Anon., *Kelso Dispensary Annual Report* (1780), pp.6-8.
[366] Ibid.
[367] Anon., *Newcastle Dispensary Annual Report* (1790), pp.16-17.
[368] See, for example, *Kelso Dispensary Minute Book*, 8 October 1787 and 7 October 1788 (HH71/1).

2.5 Staffing the Dispensaries

The relationship between a dispensary's medical staff and its lay management appears to have varied significantly between dispensaries. From the surviving records it is clear that the Kelso dispensary's managers were heavily involved in the decision-making of that organisation. Its medical staff, in 1780 comprising three physicians, two surgeons, and an apothecary, took their directions from above.[369] The administrative models of the Edinburgh and Newcastle dispensaries, however, allowed for greater involvement by their staff in management decisions. In the case of Edinburgh, its less structured approach to management allowed Duncan and his colleague, Dr Charles Webster, significant control over the formulation of the dispensary's regulations and teaching programme. These two men comprised the entirety of the Edinburgh dispensary's staff at its foundation, assisted in their work by the dispensary's medical students.[370] A subsequent addition to the dispensary staff, and its only paid employee, an apothecary, disappeared from the records in the 1790s, perhaps a result of the previously discussed financial problems which the dispensary experienced.[371]

The Newcastle dispensary had three physicians at its foundation, a total which had increased to five by 1785.[372] The work of these physicians was supplemented by a surgeon and an apothecary.[373] Each physician was to attend at the dispensary to administer to outpatients once a week and to visit patients at their homes 'as often as the circumstances of their cases shall require'.[374] The surgeon, similarly, did not have clearly designated home visiting hours. While it is likely that the surgeon's visits were restricted to patients who had undergone surgical procedures this is not stated in the dispensary's regulations. The only

[369] Anon., *Kelso Dispensary Annual Report* (1780), p.9.
[370] Anon., *A General View of the Effects of the Dispensary at Edinburgh. During the Second Year of That Charitable Establishment*, p.4. The work of the dispensary's medical students included the initial note taking of patient histories when they first visited the dispensary. Andrew Duncan, *Medical Cases, Selected from the Records of the Public Dispensary at Edinburgh, With Remarks and Observations; Being the Substance of Case-Lectures, Delivered During the Years 1776-1777* (Edinburgh, 1778), p.4.
[371] For a reference to the dispensary's apothecary, see *The Edinburgh Almanack and Scots Register* (Edinburgh, [1787]), p.57. No mention is made of an apothecary in subsequent issues.
[372] Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1778), p.34; Anon., *Newcastle Dispensary Annual Report* (1785), p.11.
[373] In certain years two 'Consulting Surgeons' were also noted, although the precise role of these individuals was not detailed. Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1779), pp.15-16.
[374] Anon., *Newcastle Dispensary Annual Report* (1790), pp.19-20.

detail given is that 'Mr Anderson will attend at the Dispensary to give advice to patients, and will visit them at their own houses whenever his assistance is required'.[375]

By contrast, the remit of the apothecary, who acted under the direction of the dispensary's physicians, is described in significant detail. The home visits which the apothecary carried out were primarily to cases where the physician had already decided upon the treatment necessary.[376] They also had a range of administrative roles, including updating the patient register and drawing up monthly and annual summaries of patient admissions.[377] The apothecary was also the only member of staff who was forbidden to undertake work outside the dispensary, including taking on private patients.[378] As a result of both the apothecary's extensive workload and the restrictions placed on their employment, they received a salary for the work they undertook.[379] Indeed, the apothecary was the only paid member of staff, as the Newcastle dispensary's physicians and surgeon were employed on a voluntary basis. Such unpaid employment of medical practitioners was common in the eighteenth century and equivalent roles are not only found at both the Edinburgh and Kelso dispensaries but at many infirmaries during this period. This structure reflects the distinctly different ways in which the role of apothecary and the roles of physician and surgeon were viewed. As the position of apothecary was a full-time post their salary would be their only source of income. By contrast, because the required working hours of the physicians and surgeon were limited this allowed them considerable opportunity to develop their private practices alongside their dispensary work.

Indeed, unpaid charitable work not only allowed dispensary physicians and surgeons to undertake paid employment; it encouraged it. Tomkins has considered the importance of charitable work alongside other unpaid endeavours in enhancing the reputation of eighteenth-century medical practitioners.[380] Such local activities could encourage private patients to utilise practitioners' services by demonstrating their professionalism and social status. The historian William Bynum, similarly, has discussed how taking up a voluntary

[375] Ibid., p.20.
[376] Ibid., pp.21-22.
[377] Ibid., p.21.
[378] Ibid.
[379] Ibid., p.33.
[380] Alannah Tomkins, 'Who Were His Peers? The Social and Professional Milieu of the Provincial Surgeon-Apothecary in the Late-Eighteenth Century', *Journal of Social History*, 44:3 (2011), pp.915-930.

medical post made it easier for practitioners to attract wealthy private clients.[381] According to Bynum, the access which these positions provided to the elite of the local community, via a charity's benefactors and fundraising events, was often a key component in advancing a practitioner's career.[382]

2.6 Conclusion

This examination of the foundation and management of the Edinburgh, Kelso, and Newcastle dispensaries has demonstrated that while there were distinct similarities between the dispensaries under study here, there were also significant differences. The emulation of a single model, that of the London General Dispensary, in the formulation of many late-eighteenth-century dispensaries resulted in many continuities in their founding regulations. In practice, however, it is clear that local factors such as the extent of a dispensary's financial support, the social status of its lay management, and the aspirations of its medical staff all impacted on the practical application of these regulations. While, in print, their operational models may appear similar, behind these written regulations a greater diversity of practices is apparent. The Kelso dispensary's position as an institution founded, in large part, by lay individuals rather than medical professionals impacted on its management approach and its aims. It focused on the operation of a functional and, ideally, well-funded dispensary service. The Edinburgh and Newcastle dispensaries, by contrast, share distinct similarities with the historiographical model of the establishment of eighteenth-century dispensaries by 'outsider' physicians keen to advance their careers and develop new experimental medical techniques.

These differences in approaches are made clear in the promotional activities of the dispensaries. A range of publications were produced based on the undertakings of the Edinburgh and Newcastle dispensaries, primarily authored by their founders Duncan and Clark. The printed material of the Kelso dispensary, by contrast, was restricted to its annual reports. This variation in approaches provides a note of caution for historiographical studies which are reliant on those institutions which provide the greatest wealth of printed

[381] W. F. Bynum, 'Physicians, Hospitals and Career Structures in Eighteenth-Century London', in W. F Bynum and Roy Porter (eds), *William Hunter and the Eighteenth-Century Medical World* (Cambridge, New York, Melbourne, 1985) pp.105-123.
[382] Ibid.

resources for historical study. Such dispensaries are more likely to fit the model of foundation by an 'outsider' physician who was promoting and advancing his career alongside providing a charitable service. Because such physicians actively developed a network of connections with other medical practitioners both locally and nationally, this ensured that their work and legacy was frequently referenced in print. Other dispensaries, such as that in Kelso, which had a less pronounced profile outside their local community do not fit this model. However, they should not be excluded from historiographical study on this basis, as this alternative approach is an important aspect of eighteenth-century dispensary development. With local support and a focus on providing for local needs, there was little interest on the part of the Kelso dispensary's managers in making a broader impact beyond their locality. Success, for them, was the provision of a needed medical resource for the community in which they were based. The extent to which this aim, of providing medical resources to those demographics of individuals previously neglected by charitable relief, was achieved will be the subject of the next chapter.

Chapter 3. Admissions and Demographic Context

The physician Andrew Duncan, in his proposal for the foundation of the Edinburgh dispensary, emphasised its utility for those sections of the population 'whose labour, even in health, cannot raise them above penury and want'.[383] In one important passage Duncan advised his readers that:

> In many diseases, relief can only be afforded to the poor, by removing them from the situation in which they may happen to be placed, to one better accommodated for their recovery. But there are other ailments, in which the cure might be conducted with equal advantage, while they continue to lodge in their own habitations, and, in some measure, to prosecute their usual employments.[384]

In drawing this distinction between residential and outpatient provision, Duncan emphasised the role of dispensaries as being to fill an existing gap in medical relief, to increase access to medical treatment for those individuals whose condition did not require inpatient care and to enable them to continue to undertake, more effectively, their familial and economic obligations. This chapter will analyse the admission policies of the Edinburgh, Kelso, and Newcastle dispensaries to consider, in each district, the extent to which this stated goal was achieved.

The previous chapter gave an overview of the admissions policies of those dispensaries. This chapter will further analyse admissions in relation to the employment, gender, and age of their patients. Furthermore, it will explore beyond the restrictions indicated in the printed regulations of the dispensaries, using the patient data held in admissions registers and individual case notes to establish the practical application of these theoretical rules. By uncovering the demographics of individuals who received treatment, contrast will be made with the admissions of these groups to local infirmaries in order to uncover the consistencies and variations between these two forms of charitable medical relief. This chapter will also consider the causes of these admission levels, the local employment and economic contexts as well as the role of choice on the part of the patient,

[383] Duncan, *Observations on a Proposal for Establishing at Edinburgh a Public Dispensary*, p.5.
[384] Ibid.

considering the range of alternative options available to them and how accessible these options were in practice. While this chapter, therefore, focuses on causal economic and social factors, it will only touch on medical provision for these individuals; the following chapters will consider, in greater detail, the diseases and treatments of dispensary patients.

3.1 Occupations of Patients Admitted

A key aim of the dispensaries established in the second half of the eighteenth century was often stated as being to prevent the poor becoming a burden upon the parish.[385] The role of the dispensary was thus distinguished from that of poor relief and depicted as a necessary addition to the services provided by existing infirmary provision. While poor law systems focused their support for the sick on those who were bedridden or otherwise incapacitated and unable to work and infirmaries, by their very nature, when providing inpatient care removed individuals from the workforce and placed them instead in ward beds, dispensaries were argued to provide a distinct and separate form of care. In cases 'where a father may still provide for those of his house', institutions such as the Edinburgh dispensary asserted that they were the bodies best suited to keeping individuals in productive employment while simultaneously providing medical care.[386]

Yet this stark distinction between the role of dispensaries in providing treatment for those in employment and that of other charitable bodies, particularly emphasised in the publicity for the Edinburgh dispensary, was not always so defined in practice. In Edinburgh, the division of roles was unusually clear because that dispensary did not have a systematic programme of home visiting and the city's infirmary did not provide an outpatient service.[387] By contrast, the fact that the Kelso and Newcastle dispensaries developed systems of home visiting for those who were bedridden demonstrates that, for them, individuals who were in a physical condition to undertake work were not their sole, or necessarily their main, focus. The importance of the dispensary in providing support for those who were of the predisposition to work, if not in working health, was, however, still emphasised by those institutions in their printed materials. The picture of the 'poor labourer

[385] This point is emphasised, for example, in the 'Plan for Establishing A Public Dispensary at Kelso For the Relief of The Indigent', *Kelso Dispensary Minute Book* (HH71/1).
[386] *The Scots Magazine*, January 1781, p.1.
[387] The subject of dispensary home visiting models is discussed in more detail in chapter two.

and mechanic' whose employment, while it 'administers to the luxuries of the rich, entail[s] upon them certain diseases and premature death', was a key component of the fundraising and publicity for the Kelso and Newcastle dispensaries.[388] The image which was created, of hard working poor individuals who would choose to labour if only their health permitted, was vital in encouraging funding and support for dispensaries in the late eighteenth century. This served to distinguish the recipients of dispensary treatment from the negative associations which pervaded regarding many of those who received poor relief.

In order to uncover the occupational demographics of dispensary patients more detailed work needs to be undertaken, work which is lacking in the current historiography. This is most likely due, in large part, to the fact that dispensaries did not commonly record the occupations of their patients during the eighteenth century. Indeed, the analysis undertaken here can provide little more than a snapshot of dispensary patient employment. Such information is lacking for the patients of the Kelso and Newcastle dispensaries and only a small sample was recorded by the Edinburgh dispensary (covering the period from 1778 to 1790).[389] As a result, the detailed demographic work carried out in broader, non-medical focused research by historians such as Sebastian Keibek, in whose studies parish records and probate inventories are used to analyse occupational structures, are not feasible in this case.[390] Within these limitations, however, the available information provides insight into variations in the use of dispensary services by occupational sector.

Figure 3.1 details the occupational categories recorded in the Edinburgh dispensary case notes. The breakdown provided here is loosely based on the methodology developed by the Cambridge Group for the History of Population and Social Structure, led by Tony Wrigley and Leigh Shaw-Taylor.[391] These categories have been altered and significantly simplified to take into consideration both the limited data available and the relatively

[388] Anon., *Plan for Instituting a Public Dispensary in Newcastle*, pp.3-4.
[389] *Practical Observations in Medicine by Andrew Duncan*, 1778-1790 (DEP/DUA/1/18-47).
[390] See, for example, Sebastian A. J. Keibek. 2017. *Using Probate Data to Determine Historical Male Occupational Structures* [Online]. Department of Economic and Social History at the University of Cambridge, working paper series no. 26. Available at: http://www.econsoc.hist.cam.ac.uk/docs/CWPESH_number_26_March_2017.pdf [Accessed: 28 November 2019]
[391] E. A. Wrigley. 2010. *The PST System of Classifying Occupations* [Online]. Department of Economic and Social History at the University of Cambridge. Available at: https://www.campop.geog.cam.ac.uk/research/projects/occupations/britain19c/papers/paper1.pdf [Accessed: 28 November 2019]

narrow spread of occupational types found amongst those seeking dispensary treatment. Indeed, even in the period covered by figure 3.1 this information was not consistently recorded, with occupations noted in only 82 of the 655 surviving patient case notes.

Figure 3.1. Occupational categories, where given, of patients admitted to the Edinburgh dispensary, 1778-1790.

Occupational Category	Number of Individuals
Construction and Labouring	
Blacksmith	4
Carpenter	1
Gardener	3
Harvest worker	2
Joiner	3
Labourer	8
Mason	7
Wright	1
Food and Drinks Industries	
Baker	2
Brewer	1
Cook	1
Footwear and Clothing	
Hat maker	1
Shoemaker	13
Tailor	2
Service Sector	
Barber / Hairdresser	2
Nurse	1
Porter	1
Servant	4
Shop worker	1
Teacher	1
Washer woman	1
Water carrier	1
Transportation	
Chairman	1
Postilion	1
Textiles	
Bleacher	1
Currier	1
Flax dresser	2
Lace worker	1
Weaver	8
Other	
Hawker	1
Printer	1
Rope maker	1
Sailor	2
Type setter	1

Source: *Practical Observations in Medicine by Andrew Duncan*, 1778-1790 (RCPE, DEP/DUA/1/18-47).

The dispensary patient records include a number of occupational categories which would characteristically be identified as those of craftsmen: two tailors, two bakers, four blacksmiths, one hat maker, one barber, one wright, and, most notably, seven masons and 13 shoemakers. Each of these occupational categories was associated with an incorporation within the city of Edinburgh.[392] An assumption should not be made that the individuals of a particular occupation were necessarily masters of that trade. Of the 82 instances where occupations were recorded, only one has been identified which corresponds with an entry in the printed directories for Edinburgh and Leith during the period of their admission to the dispensary.[393] These directories served as a method of advertising local small business and independent craftsmen and, while they did not include labourers, they would often contain entries for occupational groups such as masons and weavers. The most notable omissions from the printed directories, however, are the shoemakers and hat maker.

These individuals may have been journeymen or apprentices to a master of one of the incorporations. They may also, however, have been neither. The historian Henry Hamilton has discussed how the previous classification of individuals into master, journeyman, and apprentice was becoming less relevant in Scotland towards the end of the eighteenth century.[394] Studies of working life in Scotland have emphasised the increase, towards the end of the eighteenth century, in pauper factory labour, with some industries moving away from the traditional apprenticeship system which was based in shops and small businesses to a workshop-based model.[395] Indeed, the significant growth of groups such as shoemakers was emphasised in contemporary sources which noted the impact of the expansion in the export business of such goods.[396] The grip of the incorporations over the regulation of such professions was, therefore, loosened as a result of this expansion and diversification of their trades. Correspondingly, identification with a particular occupation, as was the case with these dispensary patients, could no longer be taken as an indication of

[392] Hugo Arnot, *The History of Edinburgh, From the Earliest Accounts to the Present Time* (Edinburgh, 1788), pp.524-530.
[393] The one corresponding entry is John Young, tailor. See Anon., *Williamson's Directory for the City of Edinburgh, Canongate, Leith, and Suburbs* (Edinburgh, 1784), p.100.
[394] Henry Hamilton, *An Economic History of Scotland in the Eighteenth Century* (Oxford, 1963), pp.345-346.
[395] Christopher A. Whatley, 'The Experience of Work', in T. M. Devine and Rosalind Mitchison (eds), *People and Society in Scotland: Volume One, 1760-1830* (Edinburgh, 1988), p.244.
[396] Arnot, *The History of Edinburgh*, p.595.

social status or relative financial stability. The employment of these patients as shoemakers or tailors did not exclude them from being in need of charitable medical relief.

By contrast, servants are relatively rare in the recorded Edinburgh dispensary occupations; only four cases were noted. This seems surprising given that historians have noted an increase in the number of servants in Scottish cities in this period, corresponding to increasing levels of urban affluence.[397] There are various possible reasons for the small number of servant admissions recorded in the dispensary records. It could simply be the case that the occupation of servant was considered less likely to have directly caused an illness than the work of a blacksmith or labourer and so this occupational information was omitted from the record. What may also have been relevant was the fact that the Edinburgh infirmary had dedicated wards set aside specifically for servants, provision which is likely to have encouraged servants and their masters to seek admission there instead.[398] Servants in the eighteenth century, who were commonly unmarried young women, were also more likely to have medical assistance supplied by their masters than were other types of employees.[399]

Indeed, it was not uncommon for the household accounts of wealthier families during this period to record the procurement of medicines 'for Self and Servants'.[400] This resource, however, could not always be relied upon and the historian Bridget Hill has noted that in some cases unwell servants were not provided for by their masters, but rather were dismissed from service as a result of their ill health.[401] Even in those cases where masters were less paternalistic in their attitudes towards their servants, however, dispensaries had to be cautious when dealing with those who were both socially superior and, indeed, their potential financial backers. This is made clear in the regulations of the Newcastle dispensary, in which it is stated that servants would not be visited at the houses of their masters 'as that might be deemed an encroachment on the province of the Family Physician

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[397] See, for example, Christopher A. Whatley, 'Work, Time and Pastimes', in Elizabeth Foyster and Christopher A. Whatley (eds), *A History of Everyday Life in Scotland, 1600 to 1800* (Edinburgh, 2010), p.278; Risse*, Mending Bodies, Saving Souls,* p.278.

[398] The Edinburgh infirmary's designation of individual wards for separate professions is discussed in more detail in chapter one.

[399] For more detailed discussion see J. Jean Hecht, *The Domestic Servant Class in Eighteenth-Century England* (London, 1956), pp.97-98; Lisa W. Smith, 'Reassessing the Role of the Family: Women's Medical Care in Eighteenth-Century England', *Social History of Medicine*, 16:3 (2003), pp.327-341.

[400] *General Fletcher Medical Accounts*, 1799 (NLS, MS.16892 ff.115).

[401] Bridget Hill, *Servants: English Domestics in the Eighteenth Century* (Oxford, 1996), pp.95-98.

and Surgeon' and, by extension, presumably also on the province of their employer.[402] This complexity is demonstrated in the case of one servant, Mary Reid, who was admitted into the care of the Edinburgh dispensary in the winter of 1782.[403] The advice given to Reid by the dispensary's physician would have directly countered the interests of her master, namely that she leave the city in order to cure her, unidentified, distemper.[404] This, however, Reid 'could not easily do' as the 'term of [her] pres[ent] service [had not yet] expired'.[405] Whether this medical guidance was shared with Reid's master is unknown, but recommending that a servant leave the employ of their master could certainly have been construed as contentious advice.

Reid is a rare example of a female patient in the Edinburgh dispensary employment data, which predominantly relates to male occupations. In only seven cases were the occupations of female patients recorded. By contrast with male patients, where their occupation was often recorded even where it was not considered to be diagnostically relevant, a woman's occupation was noted only, as in the case of Reid, when it was believed to have either directly impacted on her medical treatment or, in other instances, where it was believed to have caused her complaint. An example of this can be found in the case of Kath Gibson, 32, who visited the dispensary in the winter of 1782 suffering from back pains which were described as having resulted from her work in which she was 'much employ[e]d in carrying water to different parts of the city'.[406] That this work could cause back pain sufficiently severe to warrant a visit to the city's dispensary is demonstrated by a description of the work of Edinburgh's water caddies given by Henry Cockburn.[407] Cockburn detailed how these caddies could be found queuing with their water kegs in large numbers at the public wells which much of the city was reliant upon for their water, before travelling throughout the city, along streets and closes, and up and down many flights of stairs, to sell their water to those without access to a private supply.[408]

Occupational categories must, of course, be treated with caution. Christopher Whatley has emphasised the difficulties inherent in associating an individual with a single

[402] Anon., *Plan of the Newcastle Dispensary*, p.11.
[403] *Practical Observations in Medicine by Andrew Duncan*, 1782 (DEP/DUA/1/31), pp.293-295.
[404] Ibid.
[405] Ibid.
[406] *Practical Observations in Medicine by Andrew Duncan*, 1782 (DEP/DUA/1/30), pp.215-216.
[407] Cockburn, *Memorials of His Time*, pp.334-336.
[408] Ibid.

occupation in a period where it was common to undertake a range of jobs.[409] In addition, the historiography has emphasised the importance of clarifying both changes in the meaning of job titles over time and the extent to which the catch-all use of a single title to describe many occupations could serve to obfuscate the practical employment of individuals. Helen Dingwall has highlighted, for example, the importance of distinguishing between the use of the term 'merchant' to describe a wealthy business owner and its use to describe individual booth or street salespeople.[410] In the cases considered here, however, it is clear that the individuals were predominantly, if not entirely, carrying out manual work themselves rather than purely supervising or managing the work of others. The frequency with which an individual's complaints were described as directly caused by, or exacerbated by, their work makes this clear, whether in the form of a blow to the head in the case of Peter Chalmers, a blacksmith, or the joint pain of Robert Winter, described as having arisen from his work as a house-carpenter.[411]

The occupation of manual labourer, one of the most common categories identified in the Edinburgh dispensary case notes, could cover a wide range of practical applications, from agricultural workers to those employed in urban areas on building sites and other forms of construction and manual work. Indeed, an individual labourer could participate in a range of different types of employment depending on the time of year and the availability of work. Keibek has considered this phenomenon in some detail and developed a methodology to identify the types of work undertaken by those classified with the generic label of 'labourers' in different regions of England.[412] However, this approach requires a greater quantity of examples and contextual data than is available for this study and, as a result, in figure 3.1 the generic category of labourer is used, except in cases where the individual's occupation was specifically described as 'harvest work'.

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[409] Christopher A. Whatley, 'The Making of Industrial Scotland, 1700-1900: Transformation, Change and Continuity', in Mark A. Mulhern, John Beech and Elaine Thompson (eds), *Scottish Life and Society, A Compendium of Scottish Ethnology: The Working Life of the Scots* (Edinburgh, 2008), p.27.
[410] Helen M. Dingwall, 'The Social and Economic Structure of Edinburgh in the Late Seventeenth Century' (Ph.D. diss., University of Edinburgh, 1989), pp.275-276.
[411] *Practical Observations in Medicine by Andrew Duncan*, 5 June 1783 (DEP/DUA/1/32), pp.242-243; *Practical Observations in Medicine by Andrew Duncan*, 1783-1784 (DEP/DUA/1/20), pp.103-105.
[412] Sebastian A. J. Keibek. 2017. *Allocating Labourers to Occupational (Sub-)Sectors Using Regression Techniques* [Online]. Department of Economic and Social History at the University of Cambridge, working paper series no. 27. Available at: http://www.econsoc.hist.cam.ac.uk/docs/CWPESH_number_27_March_2017.pdf [Accessed: 28 November 2019]

Labourer is the occupational category in which a patient's medical condition was most commonly characterised in the Edinburgh dispensary case notes as having directly resulted from their work, with 'hard labour' or 'exposure to cold' cited as the most common causes.[413] Conditions described as having been caused by labouring work, however, consistently took the form of chronic rather than acute conditions, including dyspepsia and catarrh.[414] The lack of cases of occupational accidents was not restricted to labourers. Even the blow to the head suffered by Peter Chalmers, the blacksmith mentioned previously, was treated in the form of an inflammation of the eye some weeks later rather than immediately following the incident.[415] While occupational accidents were often recorded in newspapers of the period, particularly relating to incidents involving horse-drawn carts, but also in construction work, these are entirely absent from the surviving records of the Edinburgh dispensary.[416]

As the Edinburgh dispensary had no ward beds and no surgical facilities, the resources for the emergency treatment of accidents were meagre. Indeed, it was made explicit in the publicity material for the dispensary that its remit was restricted to chronic conditions, leaving the accident cases and patients with acute conditions to the care of the city's infirmary.[417] The dispensary was not entirely removed from the treatment and recovery of accident cases, however, and appears to have provided a component of a triage service, in conjunction with the Edinburgh infirmary. While this approach was certainly never the stated intention of either institution, cases have been identified of individuals admitted to the city's infirmary for medical attention as the result of an accident, after which treatment the patients were then discharged.[418] In some cases, where they were in need of further treatment, these individuals were then admitted to the dispensary, which provided a longer-term rehabilitative service.[419]

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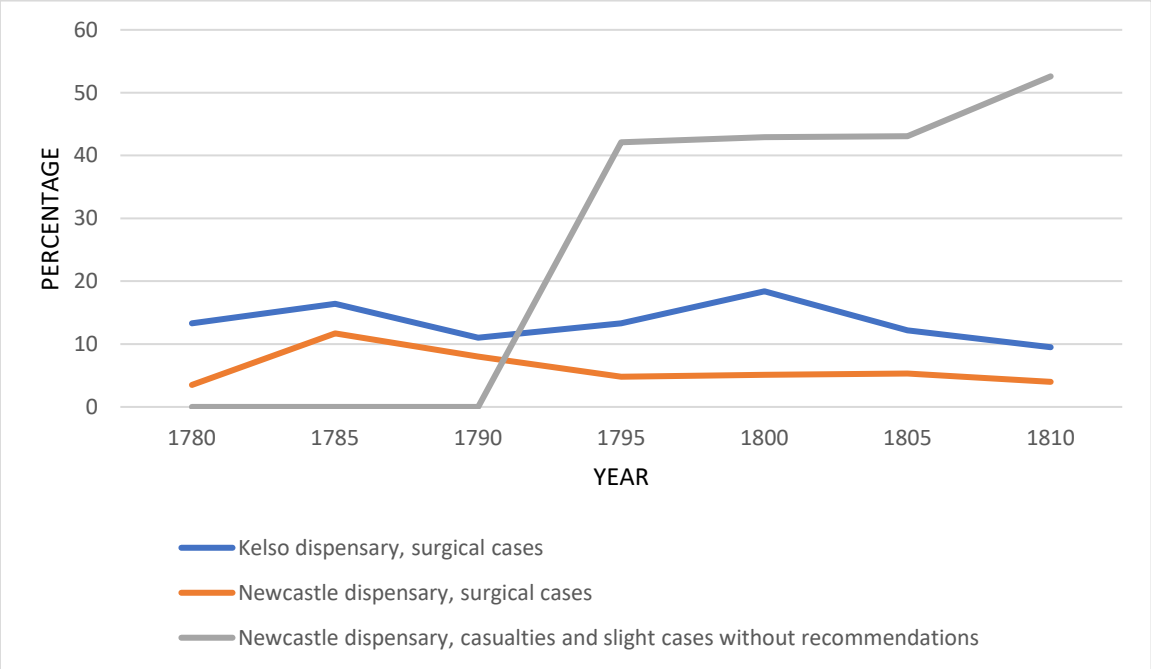
[413] Cases can be found scattered throughout the dispensary records, including Mathew Steele, *Practical Observations in Medicine by Andrew Duncan*, 12 December 1789 (DEP/DUA/1/47), n.p.; James Thomson, *Practical Observations in Medicine by Andrew Duncan*, 23 February 1787 (DEP/DUA/1/41), pp.279-280.
[414] Ibid.
[415] *Practical Observations in Medicine by Andrew Duncan*, 5 June 1783 (DEP/DUA/1/32), pp.242-243.
[416] Many examples of such cases can be found in contemporary newspapers, including a young man crushed by a cart, *Caledonian Mercury*, 10 June 1786, p.3; and two men who suffocated when repairing a well, *Caledonian Mercury*, 8 August 1781, p.3.
[417] The role of dispensaries in the treatment of chronic complaints is discussed in more detail in chapter two.
[418] See, for example, Daniel Riddell, *Practical Observations in Medicine by Andrew Duncan*, 22 May 1782 (DEP/DUA/1/29), pp.138-139.
[419] Ibid.

The lack of provision for emergency cases at the Edinburgh dispensary provides a contrast with the treatment available at the Kelso and Newcastle dispensaries. Figure 3.2 demonstrates the proportion of admissions which were classified as surgical cases at both institutions. In the case of the Newcastle dispensary, changes over time are difficult to quantify due to the introduction in 1790 of the additional category of 'casualties and slight cases without recommendation', a subject which will be discussed in more detail in chapter six. The separation of these individuals based on the process by which they accessed treatment rather than by their medical condition means that detail regarding the admissions of distinct categories of medical condition among these patients is lost.

Figure 3.2. Surgical, casualty, and slight cases admitted to the Kelso dispensary and Newcastle dispensary, as a percentage of total admissions, 1780-1810.

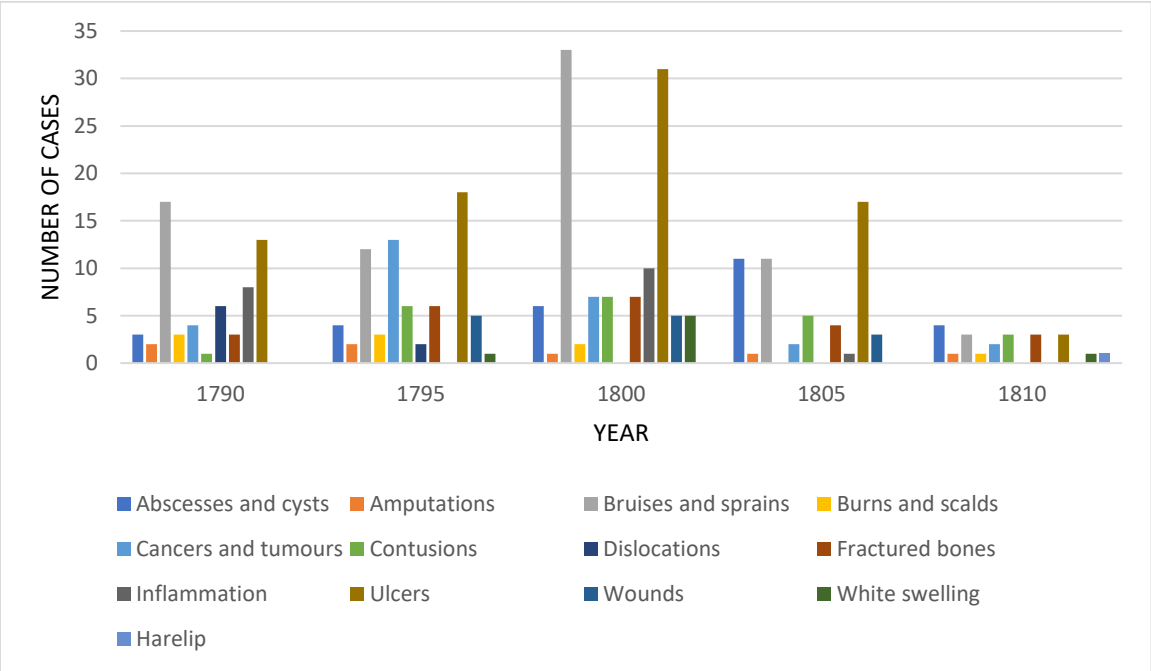


Sources: Anon., *Kelso Dispensary Annual Reports* (Berwick, Kelso, and Edinburgh, 1780-1810); Anon., *Newcastle Dispensary Annual Reports* (Newcastle, 1780-1810).

The Newcastle dispensary's method of recording these cases also makes it challenging to draw any significant conclusions about their exact nature, with the broad category of 'surgical' likely covering a broad array of complaints. By contrast, from 1790 the Kelso dispensary began to record its surgical cases in more detail, providing a breakdown of the types of conditions which were admitted under this heading (Figure 3.3). This demonstrates the complexity inherent in the analysis of this data, as the category of surgical was not used purely to denote cases where a surgical procedure was carried out, but

covered all cases treated by a dispensary surgeon rather than a physician, including ulcers and inflammations alongside amputations and dislocations. Broadly speaking, however, it is clear that surgical and, by extension, most likely, accident cases represented a significant percentage of admissions at both the Kelso and Newcastle dispensaries.

Figure 3.3. Number of surgical cases admitted to the Kelso dispensary, by diagnostic category, 1790-1810.[420]



Source: Anon., *Kelso Dispensary Annual Reports* (Berwick, Kelso, and Edinburgh, 1790-1810).

In addition to the treatment of accident cases there was one major occupational health innovation which was peculiar to a single institution. This was the creation, in 1789, by the Newcastle dispensary of a separate department specifically for 'preserving the lives of persons apparently dead'.[421] This development was inspired, in part, by work carried out elsewhere in England and on the continent on the recovery of the 'apparently dead from drowning', particularly the establishment of the Royal Humane Society of London.[422] It was

[420] White swelling was the term used to describe a form of scrofula which resulted in the build-up of fluid in joints and under the skin. See Bryan Crowther, *Practical Observations on the Disease of the Joints, Commonly Called White-Swelling; With Some Remarks on Scrofulous Abscesses* (London, 1797).
[421] Anon., *Newcastle Dispensary Annual Report* (1790), p.10.
[422] Anon., *Proposals for Recovering Persons Apparently Dead by Drowning, and Suffocation from Other Causes* (Newcastle, 1789), p.3. The Humane Society for the Recovery of Persons Apparently Dead by Drowning was instituted in London in 1774, with numerous similar societies established across Europe around the same time. Anon., *Reports of the Humane Society, Instituted in the Year 1774, For the Recovery of Persons Apparently Drowned* (London, 1776); Alexander Johnson, *An Account of Some Societies at Amsterdam and Hamburgh for the Recovery of Drowned Persons, and of Similar Institutions at Venice, Milan, Padua, Vienna, and Paris*

also preceded by a development at the Kelso dispensary, where some unidentified 'apparatus' to treat the partially drowned was donated in 1778 by Walter Scott, Writer to the Signet.[423] The Newcastle dispensary, however, went to significantly greater lengths in its provision of this service. Receiving houses for drowning cases were established near the river Tyne in Newcastle, North Shields, South Shields, Howdon Dock, and Lemington, with instruments and medicines placed in each.[424] The equipment primarily consisted of various pipes and tubes and a set of bellows with which breathing could be reintroduced by the inflation of the lungs and then spirits, oil of peppermint, or other liquids could be inserted.[425] Funds were made available both to cover any costs an individual might incur when receiving a suffering individual at their home and in order to pay any bystander who was willing to assist.[426] Guidance on the process of resuscitation and treatment was also written up and distributed to the local population.[427]

The Newcastle dispensary's new department was not only concerned with the recovery of drowning cases, but also cases of 'suffocation from the noxious vapours of coal-mines; and other causes'.[428] In a study carried out by mining entrepreneur and campaigner Henry Gray MacNab in 1792 it was concluded that 36,900 individuals were employed throughout the Tyne and Wear area in occupations related to coal mining, a total which included the boatmen responsible for transporting coal along the Tyne.[429] Although accurate statistics regarding mining and maritime-related deaths do not survive for the period, health concerns relating to these occupations were noted in contemporary sources.[430] The high levels of mortality both upon the Tyne river and in coal mining work in the region were highlighted in the promotion of the dispensary's new department.[431] Effort

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[London, 1773]. For a more detailed discussion of the national and international influence of the London Humane Society, see Luke Antony Francis Davidson, 'Raising up Humanity: A Cultural History of Resuscitation and the Royal Humane Society of London, 1774-1808' (Ph.D. diss., University of York, 2001), pp.148-157.

[423] *Kelso Dispensary Minute Book*, 1 May 1778 (HH71/1).

[424] Anon., *Proposals for Recovering Persons Apparently Dead by Drowning*, p.4.

[425] Ibid., pp.14-16.

[426] Ibid., p.4.

[427] Ibid.

[428] Ibid.

[429] Henry Gray MacNab, *Letters Addressed to the Right Honourable William Pitt, Chancellor of the Exchequer of Great Britain; Pointing Out the Inequality, Oppression, and Impolicy of the Taxes on Coal: and A Substitute for These Taxes on all Coals Consumed in England and Scotland* (London, 1793), pp.16-20.

[430] Thomas Oliver, *The Picture of Newcastle Upon Tyne, Being a Brief Historical & Descriptive Guide to the Principal Buildings, Streets, Public Institutions, Manufactures, Curiosities, &c* (Newcastle, 1812), pp.275-279.

[431] Anon., *Proposals for Recovering Persons Apparently Dead by Drowning*, p.3.

and expense should not, of course, be confused with impact. In spite of the significant undertakings in relation to this work, only one individual was recorded as having been saved by this method between the department's establishment in 1789 and 1810.[432] While the foundation of the preservation department, as it came to be known, provides insight into how local concerns regarding occupational health could influence the work of a dispensary, it also demonstrates how this could, in practice, have little impact on the health of the population.

The role of the dispensaries in treating those who had been injured in work-related accidents, however, was complicated by a range of concerns. This included the potential for conflict between the dispensaries and local infirmaries if the division between their remits, with the former focusing on chronic complaints while the latter undertook the treatment of more acute conditions, was not adhered to. Overall, however, it appears that dispensaries were willing to accept all those who presented themselves for treatment, from washer women and street hawkers to masons and tailors. Inhibiting factors were primarily restricted to the desire to avoid any potential offence to family physicians, employers, or infirmary managers.

3.2 Gendering Admissions

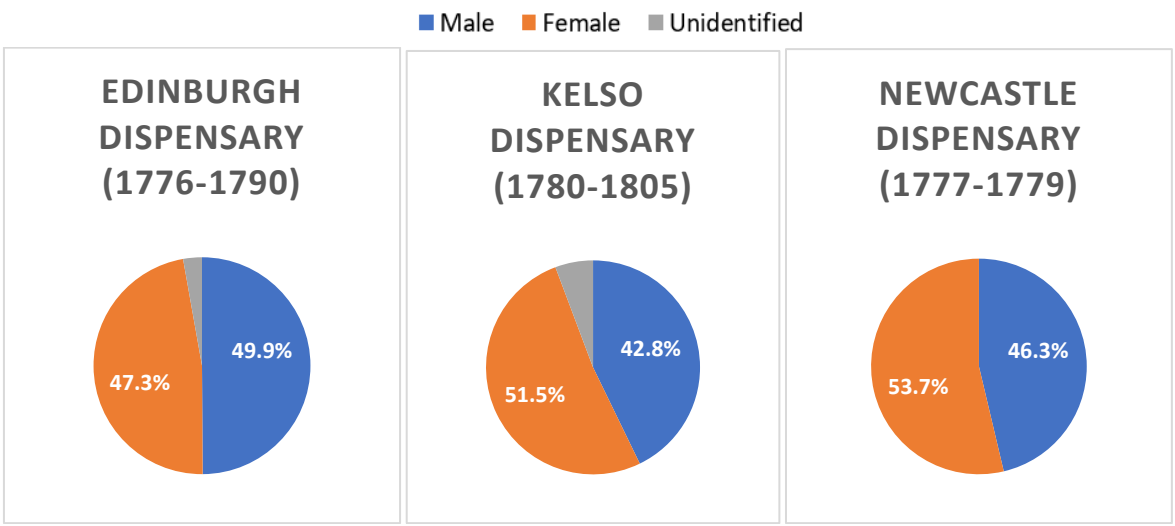
While the publicity material of the Edinburgh dispensary emphasised the occupational role of the father who provided for his family, the importance of the mother, who 'tend[ed] her helpless infants', was also identified.[433] The activities, as characterised here, of men and women may have differed, but the role of the dispensary in catering for both was clear. The relationship between gender and patient admissions at the Edinburgh, Kelso, and Newcastle dispensaries should not, however, be cast as a simple one. Avoiding the characterisation of gender as simply shorthand for the study of women, this section will consider the variations between the admission of men and women in the context of both biological differences between the sexes and the biases contained within contemporary social constructions of gender.

[432] Anon., *Newcastle Dispensary Annual Report* (1810), p.10.
[433] *The Scots Magazine*, January 1781, pp.1-2.

Figure 3.4 demonstrates the gender composition of patient admissions at the Edinburgh, Kelso, and Newcastle dispensaries. Unfortunately, the limitations of the available data do not allow us to determine changes over time. Within these limitations, however, the evidence shows an approximate equivalence between the rates of admission of female and male patients, with Kelso and Newcastle showing a slight imbalance in favour of female admissions. These findings stand in stark contrast to the historiographical studies of eighteenth-century institutional medical provision, which predominantly focus on infirmaries rather than dispensaries, where commonly a significant bias is found in favour of male admissions.[434] So what is the cause of this disparity? One factor is that the Edinburgh, Kelso, and Newcastle dispensaries all lacked explicit regulations which excluded the admission of particular sections of the female population. Indeed, in the case of Newcastle, the dispensary there contrasted their own relatively open access to women with the more restrictive approach of the local infirmary.[435] This restrictive policy took the form of prohibiting the admission of women who were 'big with Child', regardless of the medical condition which they were suffering from.[436]

[434] See, for example, Borsay, *Medicine and Charity in Georgian Bath*, pp.227-228.
[435] Anon., *Newcastle Dispensary Annual Report* (1778), p.18.
[436] Anon., *Statutes, Rules, and Orders for the Government of the Infirmary for the Sick and Lame Poor of the Counties of Durham, Newcastle Upon Tyne and Northumberland* (Newcastle, 1752), p.12. The same restriction was included in the subsequent surviving printed regulations. See Anon., *A Code of Statutes and Rules for the Government of the Infirmary for the Counties of Newcastle Upon Tyne, Durham, and Northumberland*, pp.8-9. The subject of infirmary admission restrictions is discussed in more detail in chapter one.

Figure 3.4. Gender composition of patients at the Edinburgh, Kelso, and Newcastle dispensaries, as a percentage of total admissions, 1776-1805.[437]



Sources: *Practical Observations in Medicine by Andrew Duncan*, 1776-1790 (RCPE, DEP/DUA/1/11-47); *Kelso Dispensary Patient Registers*, 1780-1805 (NRS, HH71/7-8 and HH71/43); Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1779).

Similarly, the Edinburgh infirmary also restricted access based on gender, with those women who had young children barred from admission, unless it was clear that their children were taken care of elsewhere, in order to prevent the infirmary from being 'burdened with the Maintenance of such Children' or other patients being 'disturbed with their Noise'.[438] While historians have argued that such policies may have encouraged women to use infirmary outpatient rather than inpatient services, in the case of the Edinburgh infirmary this was not an option which was available to them.[439] There were, of course, other possible solutions. It is likely that some women were able to find close relatives or members of their community to care for their children while they were absent. Another potential resource for women seeking admission into the infirmary was to have their children taken into a workhouse for the duration of their treatment. Examples can be found scattered throughout the minutes of city workhouses of such cases, including Mrs Pryse, whose children, aged seven, five, and two, were admitted to the St. Cuthbert's

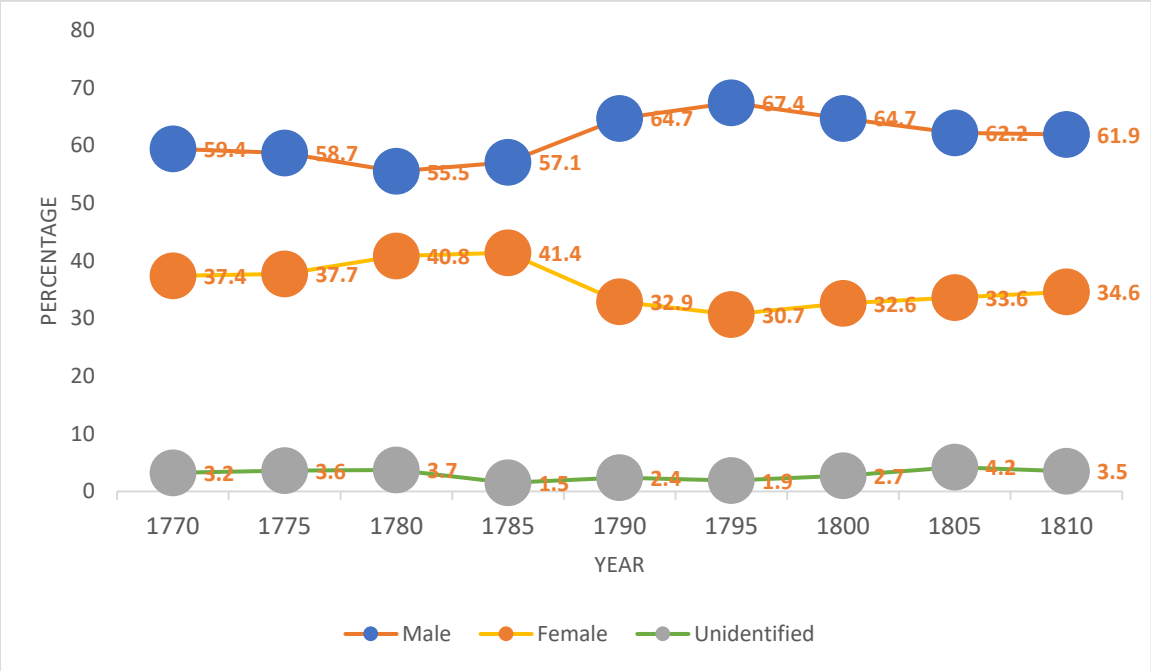
[437] The time periods covered here, as detailed in the graph, vary between the dispensaries depending upon the availability of source material.
[438] Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1749), p.49. Although the regulations were slightly revised in 1778 to include a mention that in some cases children could be admitted, the broader statute remained in place. See Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1778), p.76.
[439] See, for example, Levene, Reinarz and Williams, 'Child Patients, Hospitals and the Home in Eighteenth-Century England', p.24.

Charity Workhouse in 1787 while their mother underwent treatment at the Edinburgh infirmary.[440] While this option was available to some, however, the restrictions in access to poor relief discussed in chapter one demonstrate that it would only have been so in a limited number of cases.

The regulations of the dispensaries contained no equivalent restrictions to that of the Edinburgh infirmary regarding mothers who were accompanied by their children. It is important, however, to avoid ascribing too quickly to benevolence what it is perhaps more likely in this instance to have been the result of simple logistics. The acceptance of children accompanying their mothers would certainly have resulted in fewer administrative complications, such as the need to provide food and accommodation for the children, in an institution based primarily on outpatient rather than inpatient care. Regardless of the impetus behind this divergence in the gendering of admission policies, the impact of such measures was significant. Figures 3.5 and 3.6 demonstrate that both the Newcastle and Edinburgh infirmaries maintained a constant and statistically significant imbalance in favour of male patients, far greater than the imbalance in favour of female patients at the Kelso and Newcastle dispensaries detailed in figure 3.4. In the case of the Edinburgh infirmary, in 1770 over 20 per cent more male patients were admitted than females, rising to a peak in 1795 of almost 37 per cent more male patients. It would be overly simplistic, however, to characterise this imbalance as having resulted entirely from the explicit admission policy restrictions which infirmaries placed on certain categories of women. A range of other factors also acted to encourage a bias in favour of male admissions.

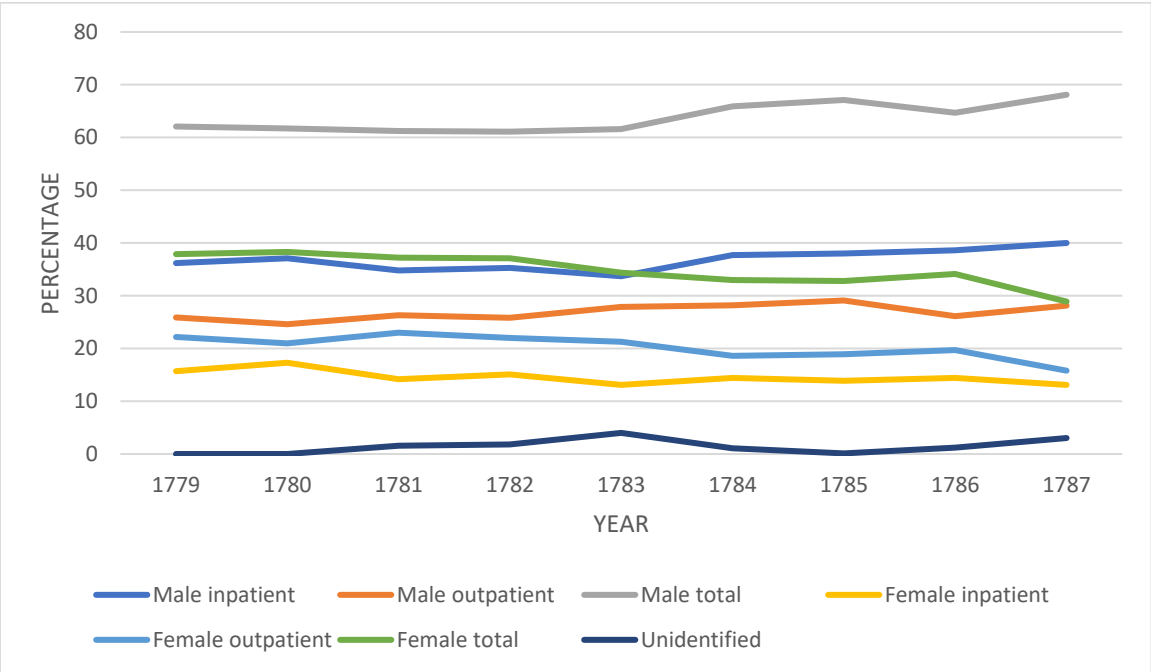
[440] *St. Cuthbert's Charity Workhouse Minute Book,* 7 August 1787 (SL222/1/7).

Figure 3.5. Gender composition of patients at the Edinburgh infirmary, as a percentage of total admissions, 1770-1810.



Source: *Royal Infirmary of Edinburgh General Register of Patients*, 1770-1810 (LHSA, LHB1/126/3-19).

Figure 3.6. Gender composition of patients at the Newcastle infirmary, as a percentage of total admissions, 1779-1787.



Source: *Newcastle Infirmary Admission Registers*, 1779-1787 (TWA, HO.RVI/117/1-2).

At the Edinburgh infirmary the designation of wards specifically for sailors and seamen ensured that these male-only professions had priority in the selection of medical cases for admission. Indeed, the timescale of the significant increase in male admissions, beginning in the late 1780s, which is demonstrated in figure 3.5 directly corresponds with the period of increased provision for military personnel discussed in chapter one. However, the divergence in the gender balance of infirmary admissions cannot be entirely attributed to the emphasis placed on these occupations given that, as previously noted, similar imbalances in the ratio of male to female infirmary admissions can be found at other infirmaries during this period, including those in Newcastle and Bath. Neither of these institutions held similar policies to the Edinburgh infirmary on the admission of specifically gendered forms of employment, such as military personnel.

There were other administrative processes which directly impacted on the variations uncovered in the rates of gendered admission between the dispensaries and infirmaries. The process of gaining admission to a dispensary was neither strict, nor particularly complex.[441] By contrast, the process of gaining admission to an infirmary could be a complex and lengthy one where, in addition to supplying a recommendation, a prospective patient could also be required to supply a cash deposit to cover costs in the result of their death and was often expected to procure administrative paperwork, such as a clinical report, or an assessment of their personal circumstances.[442] The infirmary system of recommendation, therefore, favoured those who were part of a community support system, whether through their employment or a personal or familial relationship. Each recommender could only put forward a limited number of patients, usually based on the level of funds which they had subscribed to the infirmary. Thus, the prospective patients not only needed connections, they also needed those connections to view them as a priority for medical treatment. In short, the process of filtering out those considered inappropriate for infirmary care was carried out, not just by the institution itself, but by the wider community as well.

The agency of the women themselves should not, however, be lost in this narrative. Individual choice, while increasingly studied in the context of eighteenth-century poor relief,

[441] The subject of dispensary admissions policies is discussed in more detail in chapter two.
[442] For more information on the variation of infirmary admission policies, the complexity they could entail, and their impact on the admission of women patients, see Borsay, *Medicine and Charity in Georgian Bath*, pp.228-230.

has received much less attention in the case of medical institutions.[443] A lack of available sources has likely influenced this decision as, unlike poor relief authorities, medical institutions rarely recorded those who requested admission and were then rejected. Moreover, choice is a nebulous concept in the context of the various constraints on accessing charitable medical care previously discussed; if an individual thought their application would be unsuccessful, this may have disinclined them from even attempting to gain admission. Indeed, Tomkins has considered poor women in this period to have had 'only narrow room for manoeuvre' in the formulation of survival strategies.[444] The possibility, however, that women chose, within the limited range of options available to them, not to seek admission as inpatients should not be discounted. Outpatient dispensary provision offered the distinct advantage of allowing the patient to remain with their family while undergoing treatment, providing a viable option to those who lacked the economic or social resources necessary to ensure the care of their children in their absence.

Infirmary outpatient care played a similar role to that of dispensaries in this regard, as figure 3.6 demonstrates. Even within the lower levels of female admissions witnessed at the Newcastle infirmary, women were consistently more likely to be admitted as outpatients rather than inpatients while, for men, the converse was the case. Whether this was the result of individual choice on the part of the patient or the imposition of administrative restrictions is again unclear, but the possibility that these women actively chose to avoid leaving their homes for the duration of their treatment should not be discounted. Indeed, whether the treatment was provided by dispensaries or infirmaries, it appears that outpatient provision, rather than inpatient care, was consistently the option most utilised by female patients. More flexible to women's familial needs and more accessible to their limited economic and social means, outpatient provision provided a key resource to those individuals when it was impossible, or impracticable, to gain access to an infirmary ward bed.

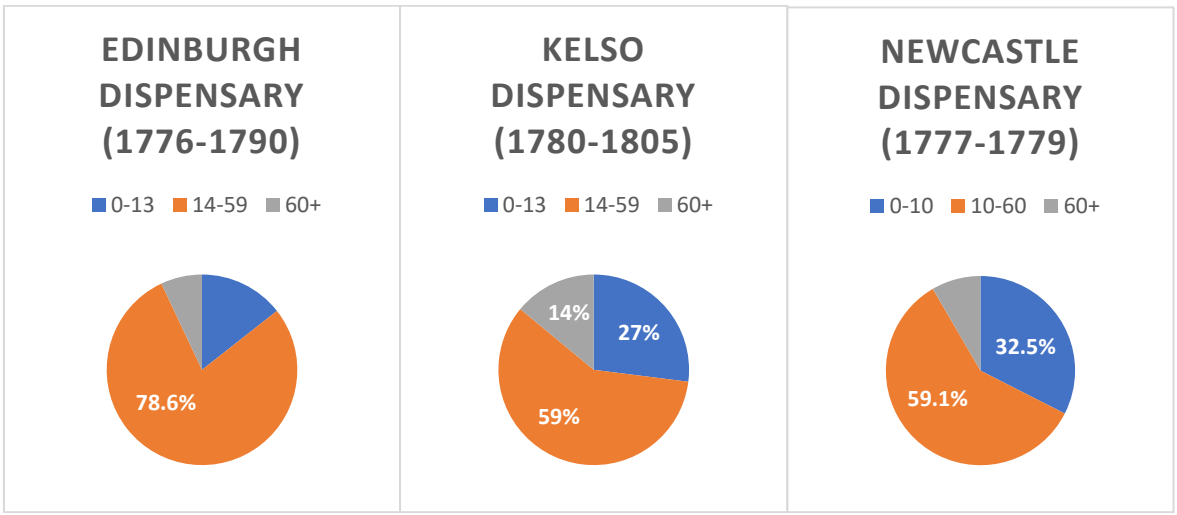
[443] Recent examples of the study of choice in the context of poor relief include: Steven King, Thomas Nutt, and Alannah Tomkins (eds), *Narratives of the Poor in Eighteenth-Century Britain. Volume One: Voices of the Poor, Poor Law Depositions and Letters* (London, 2006); Peter King, 'Social Inequality, Identity and the Labouring Poor in Eighteenth-Century England', in Henry French and Jonathan Barry (eds), *Identity and Agency in England, 1500-1800* (Basingstoke and New York, 2004), pp.60-83.
[444] Alannah Tomkins, 'Women and Poverty', in Hannah Barker and Elaine Chalus (eds), *Women's History: Britain, 1700-1850: An Introduction* (Abingdon and New York, 2005) p.154.

3.3 Provision for the Young

The utilitarian policies of the Edinburgh and Newcastle infirmaries, in focusing on the treatment of those who could be returned to productive employment, had clear implications for the age, as well as gender, of their patient admissions. By contrast, the apparent greater leniency of the Edinburgh, Kelso, and Newcastle dispensaries in relation to the economic productivity and social status of their patients would suggest that, as well as being more open than the infirmaries to the admission of women, they would also have been more accessible to those at the extremes of the age demographic and, indeed, the policies of the dispensaries towards children, where they were explicitly stated, were often encouraging of their admission. The Newcastle dispensary particularly emphasised that part of its primary focus was the treatment of diseases of children.[445] The outcome of such a policy is evident in figure 3.7, which demonstrates that almost a third of that institution's patient admissions between 1777 and 1779 were under the age of 10. The age categories used in this figure for the Newcastle dispensary are dictated by the form in which they were originally recorded and so unfortunately the levels of admission of older children are lost in this analysis.

[445] Anon., *An Account of the Newcastle Dispensary, for the Relief of the Poor*, p.6.

Figure 3.7. Age range of patients at the Edinburgh, Kelso[446], and Newcastle[447] dispensaries, as a percentage of admissions, 1776-1805.



Sources: *Practical Observations in Medicine by Andrew Duncan*, 1776-1790 (RCPE, DEP/DUA/1/11-47); *Kelso Dispensary Patient Registers*, 1780-1805 (NRS, HH71/7-8 and HH71/43); Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1779).

In the analysis of the Edinburgh and Kelso dispensaries childhood is here defined as those under 14 years old, based on the age at which apprenticeship commonly began.[448] The Kelso dispensary, by contrast to its Newcastle equivalent, was silent in its regulations regarding its overarching approach to the treatment of young children, although it had no explicit regulations to bar or constrain the level of child admissions. As a result, as figure 3.7 demonstrates, close to a third of admissions to the Kelso dispensary were aged under 14 years. The Edinburgh dispensary, while also less explicit about its aims with regard to the treatment of children than its Newcastle counterpart, noted that the parents of a patient were responsible for ensuring that the medical directions given were observed if the patients themselves were under age, demonstrating its willingness to accept and treat

[446] For the Kelso dispensary, each individual patient visit has been counted as a distinct case. The findings given here are the result of the analysis of five-year increments (i.e. 1780, 1785, 1795, 1800, and 1805). No patient registers survive for 1790 and so this year has been omitted from the analysis. Likewise, for the year 1810, while records exist up to September of that year, as patient data does not survive for the full year it has been excluded from this analysis.

[447] The analysis given here of the Newcastle dispensary, both in terms of dates covered and age ranges used, is based on the summary given in the dispensary's annual report covering 1777-1779. Later annual reports do not contain an equivalent breakdown by age.

[448] More detailed discussion of the concept of childhood and broader notions of age and ageing in the eighteenth century are beyond the scope of this study. For more in-depth analysis of these subjects useful sources include: Anja Müller (ed.), *Fashioning Childhood in the Eighteenth Century: Age and Identity* (Aldershot and Burlington, 2006); Helen Yallop, *Age and Identity in Eighteenth-Century England* (London and Brookfield, 2013).

young patients.[449] The Edinburgh dispensary, however, had the lowest proportion of child patients of the dispensaries under consideration here.

When investigating the significance of the dispensary rates of admission of children it is first necessary to consider this group's representation in the broader population. According to Tony Wrigley and Roger Schofield, in their population study of England, approximately 35 per cent of the English population were aged 14 years or under in 1800, with this total having increased over the course of the eighteenth century and continuing to increase into the nineteenth century.[450] Turning to eighteenth-century Scotland, the difficulty of determining accurate demographic data has been considered by historians, particularly Michael Flinn in his study of the population history of Scotland, citing factors such as the unreliability of parish records in a period of increasing religious non-conformism.[451] However, two censuses were carried out in which age data was recorded which are close in date to the period under consideration here, the 1755 Scottish census of Dr Alexander Webster and the 1811 British parliamentary census.[452] Although the data available only allows the identification of children aged 10 and under, the censuses show a notable consistency, with that group comprising 25.5 per cent of the overall total in each study.[453] It should be borne in mind, however, that in addition to potential fallibilities in this data, particularly in the case of the Webster census, these statistics relate to the entire population of Scotland.[454] While accurate data is not available for the city of Edinburgh, for the town of Kelso, by contrast, age-related data is available for the later eighteenth century, collected by Sinclair in his statistical account.[455] Although the format in which this data was

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[449] Anon., *A General View of the Effects of the Dispensary at Edinburgh. During the Second Year of that Charitable Establishment*, p.8.
[450] E. A. Wrigley and R. S. Schofield, *The Population History of England 1541-1871: A Reconstruction* (London, 1981), p.216.
[451] Michael Flinn (ed.), *Scottish Population History from the 17th Century to the 1930s* (Cambridge, 1977), pp.203-209.
[452] James Gray Kyd (ed.), *Scottish Population Statistics including Webster's Analysis of Population 1755* (Edinburgh, 1952); Anon., *Abstract of the Answers and Returns Made Pursuant to an Act, Passed in the Fifty-first Year of His Majesty King George III* (London, 1811).
[453] John Sinclair, *Analysis of the Statistical Account of Scotland; with a General View of the History of That Country, and Discussions on Some Important Branches of Political Economy. Volume One* (Edinburgh, 1825), p.157.
[454] For a more detailed discussion of the problem of the reliability of Webster's census data, see Rosalind Mitchison, 'Webster Revisited: A Re-examination of the 1755 Census of Scotland', in T. M. Devine (ed.), *Improvement and Enlightenment: Proceedings of the Scottish Historical Studies Seminar, University of Strathclyde, 1987-88* (Edinburgh, 1989), pp.62-76.
[455] Douglas, 'Parish of Kelso', p.586.

recorded, once again, makes its analysis problematic, we can at least say that, based on the figures which Sinclair provided, 26.2 per cent of the town's population was aged under 10 years in the final decade of the eighteenth century.[456]

It appears, therefore, that the Newcastle dispensary, taking into consideration the variations in the age ranges covered by the available data, accepted child patients at a rate either consistent with, or possibly slightly above, their level of representation in the general population. The admission of children to the Kelso dispensary, similarly, appears to approximately correspond with local demographic data for the town. The Edinburgh dispensary, by contrast, accepted significantly fewer patients aged under 14 than would be expected given what is known about their representation in the broader population. As this dispensary did not explicitly exclude or restrict children from admission, other potential causes of this variation must be considered.

Firstly, it is important to note significant differences in the source material for this information. The records relating to the Newcastle and Kelso dispensaries appear to be comprehensive, detailing all patient admissions at these institutions during the period in question. The records of the Edinburgh dispensary, by contrast, are a selection of patient case notes compiled for use in the training of medical students. This naturally raises the question: Could the imbalance be located, not in the rates of admission, but in a decision not to use child patients for teaching purposes, due to a lack of interest in the study of children? The historian George Rosen has argued that the 'branch of medicine known today as paediatrics was largely terra incognita in the eighteenth century'.[457] While more recent studies have revealed that the number of texts published on the subject of child health increased towards the end of the eighteenth century, in some instances the physicians writing these tracts can be found explicitly identifying and critiquing the lack of a significant wider interest by their contemporaries in the study of children.[458]

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[456] Ibid.

[457] George Rosen, 'A Slaughter of Innocents: Aspects of Child Health in the Eighteenth-Century City', in Ronald C. Rosbottom (ed.), *Studies in Eighteenth-Century Culture, Volume Five* (Madison and London, 1976), p.299.

[458] A. R. Colón and P. A. Colón, *Nurturing Children: A History of Pediatrics* (Westport, 1999), pp.148-180; Adriana S. Benzaquen, 'The Doctor and the Child: Medical Preservation and Management of Children in the Eighteenth Century', in Anja Müller (ed.), *Fashioning Childhood in the Eighteenth Century: Age and Identity* (Aldershot, 2006), pp.13-24. George Armstrong, founder of the London Dispensary for the Infant Poor, wrote that the study of diseases of infants had been 'much neglected'. See George Armstrong, *An Account of the Diseases Most Incident to Children, From the Birth Till the Age of Puberty* (London, 1783), p.1.

Furthermore, particular difficulties which arose in the diagnosis and treatment of children would have had an additional negative impact on the usefulness of their case studies for medical teaching. It was noted on a number of occasions by Duncan that, as young children were 'incap[able] of giving any acc[oun]t whatever' of their own condition, it was 'often diffic[ult] to form any prop[er] idea of [their] compl[aint]'.[459] This inability on the part of infants to assist in their diagnosis was compounded by the apparent need for caution in trusting the accuracy of the testimonies of their parents. This concern is exemplified in the case of Duncan Kennedy, who was admitted into the Edinburgh dispensary in the summer of 1782 aged two and a half.[460] Kennedy suffered from a number of symptoms, including a tumour on his neck, which led the diagnosing physician to believe that the condition was scrofula and, in this case, was likely to prove fatal.[461] The child's parents, however, remained convinced that the swelling was due to an accidental fall.[462] Kennedy's patient records noted that it was 'but too common for parents… to deceive themselves from anxiety [in order] to be able to entert[ain] [the] hope that such [an] affect [is] not scroph[ula]'.[463]

It cannot be assumed, however, that the low rates of admission of those under 14 years of age can be accounted for solely by the omission from the surviving records of a significant proportion of the child cases who were treated. It is also relevant to consider the alternative resources in the city of Edinburgh which were open to young children, resources which were not available in the other districts under consideration here. Edinburgh had more extensive workhouse provision in the second half of the eighteenth century than Newcastle (while the district of Kelso had none).[464] This may be particularly relevant when considering the charitable resources available to children as historians have emphasised that workhouses admitted a disproportionately high level of children.[465] Another notable difference between the resources available in Edinburgh and those in Newcastle and Kelso were the city's hospitals, institutions which were established for the care of orphans or

[459] James Frazer, *Practical Observations in Medicine by Andrew Duncan*, 1783 (DEP/DUA/1/34), p.24.
[460] *Practical Observations in Medicine by Andrew Duncan*, 1782 (DEP/DUA/1/29), p.86.
[461] Ibid., pp.91-94.
[462] Ibid., p.93.
[463] Ibid.
[464] The subject of workhouse provision is discussed in more detail in chapter one.
[465] Siena, 'Hospitals for the Excluded or Convalescent Homes?', p.10; Elizabeth M. R. Lomax, *Small and Special: The Development of Hospitals for Children in Victorian Britain* (London, 1996), p.2.

children of 'decayed' parents who were not in a position to provide for them at home.[466] Seven such institutions had been founded in Edinburgh by the end of the eighteenth century, housing around 400 individuals.[467] There are a number of qualifiers, however, when considering the impact of these institutions in providing for the sick children of the city. Firstly, eighteenth-century usage of the term hospital did not necessarily identify an institution as having a primarily medical remit; indeed use of the descriptor could vary significantly, having been applied to workhouses, almshouses and, in this instance, boarding schools.

The distinguishing feature of these institutions, by contrast to the charity schools which could be found in Kelso and Newcastle during this period, was the provision by the Edinburgh hospitals of accommodation as well as educational instruction.[468] In addition, some of these hospitals restricted access to the children of parents who were members of particular occupational groups, such as George Watson's Hospital, where admission was available only to the descendants of merchants and church ministers.[469] Others, such as the city's Orphan Hospital, had a significantly broader remit, focusing on the children of the 'indigent' who were either dead or unable to maintain them.[470] However, the Orphan Hospital was also explicit in its 1777 printed regulations that children could only be admitted if they were found to be 'free of every infectious distemper and incurable disease'.[471] These limitations, however, should not be taken as an indicator that no medical care was provided by the hospitals to the children under their charge and indeed evidence survives to

[466] The emphasis on provision for the children of decayed individuals can often be found in the regulations of these institutions. See, for example, Anon., *The Rules and Statutes of George Watson's Hospital* (Edinburgh, 1724), pp.1-2.
[467] These institutions were: Heriot's Hospital (founded 1624), the Merchant Maiden' Hospital (founded 1695), the Trades Maiden Hospital (founded 1704), George Watson's Hospital (founded 1723), the Orphan Hospital (founded 1733), John Watson's Hospital (founded 1759) and Gillespie's Hospital (founded 1796). See Deborah S. Symonds, 'Introduction', in Deborah S. Symonds (ed.), *Narratives of the Poor in Eighteenth-Century Britain. Volume Two: Voices from the Street* (London and Brookfield, 2006), pp.x-xi. Arnot gave the figure as 390 children provided for by these institutions, however, as his total covered only five of the seven institutions it does not comprise the full total of children in such institutional care. See Arnot, *The History of Edinburgh*, pp.561-569.
[468] For a general overview of the Kelso and Newcastle charity schools, see Douglas, 'Parish of Kelso', pp.592-593; E. *Mackenzie, A Historical and Descriptive View of the County of Northumberland, and of the Town and County of Newcastle Upon Tyne, with Berwick Upon Tweed, and Other Celebrated Places on the Scottish Border, Volume Two* (Newcastle, 1811), pp.740-743.
[469] Anon., *The Rules and Statutes of George Watson's Hospital*, p.2.
[470] Anon., *Statutes of the Corporation of the Orphan Hospital and Workhouse at Edinburgh* (Edinburgh, 1777), pp.2-3.
[471] Ibid., p.11.

demonstrate that, at least in some cases, physicians were employed to provide inhouse treatment to sick children.[472] The growth of such hospital schools added to the existing network of relief available to poor children within cities such as Edinburgh. It appears, therefore, that the availability of alternative charitable support systems may have had a greater impact on the rates of dispensary child admissions than any formal policies of these dispensaries. Poor children were considered particularly appropriate candidates for relief by a range of institutions; to provide for them would serve to 'rescue' them and make them 'useful to society'.[473] More complex, however, was the relationship between the elderly and charitable medicine.

3.4 Provision for the Old

Before considering the subject of dispensary provision for the elderly in detail it is essential to address the question of what precisely was meant by this term. The Edinburgh dispensary patient case notes provide examples of the categorisation of old age beyond that of merely numerical descriptors. When James Wilson sought admission to the dispensary in the winter of 1782 for the treatment of a pimply rash he was described by one of the dispensary's physicians as a 'robust man' whose employment, while unspecified, resulted in him being 'much exposed to cold'.[474] Within a few weeks his treatment was deemed successful and Wilson was discharged.[475] Aged 69, Wilson was one of the older patients treated at the dispensary and yet his age was mentioned only as a matter of administrative record.[476] No indication was made in the dispensary notes that Wilson was considered to have been particularly aged, nor was there any implication that his advanced years influenced either his medical condition or the treatment which was prescribed. That Wilson was still in employment was not recorded as exceptional or significant, beyond the impact which harsh working conditions had on an individual's health, regardless of their age.

[472] For example, a letter from a physician, David Poulis, to Sir James Clerk in 1770 detailed that Poulis would temporarily have to give up his salary as the physician to George Heriot's Hospital. *Letter to Sir James Clerk from Dr David Poulis*, 15 August 1770 (NRS, GD18/5498).
[473] Anon., *Statutes of the Corporation of the Orphan Hospital and Workhouse at Edinburgh*, p.2.
[474] *Practical Observations in Medicine by Andrew Duncan*, 1782 (DEP/DUA/1/31), pp.31-34.
[475] Ibid., p.34.
[476] Ibid., p.31.

Wilson's case demonstrates a level of fluidity to the concept of old age in the eighteenth century. The historian Susannah Ottaway, in her own study of ageing in England during this period, has demonstrated that the physical health of the individual was more significant in defining their entry into old age than a primarily chronological signifier.[477] Thus, in the Edinburgh dispensary records, Wilson could be considered as robust, with his relatively mild medical condition, while in other cases an individual could be 'ruined & worn out by disease' at a significantly younger age.[478] Consequently, Isabel Angus, admitted to the Edinburgh dispensary in 1787 aged 60, nine years Wilson's junior, was described as being 'far adv[anced] in life' and whose condition, anasarca, or the accumulation of fluid in her legs, was considered much more serious, to the extent to which it was recorded that it would 'not [be] surp[rising] if [it is] in [the] end fatal'.[479]

While these dispensary case studies demonstrate that the precise age at which an individual was classified as elderly was not exact, historians studying the eighteenth century have commonly characterised the age of 60 as 'the gateway to old age'.[480] Using this benchmark here for the purposes of statistical analysis, figure 3.7 demonstrates that, between 1779 and 1790, 7 per cent of admissions to the Edinburgh dispensary were in the age range of 60 or over. This breakdown, of course, only covers those patients whose ages were recorded. Duncan did not, unfortunately, heed his own advice, delivered at clinical lectures to his medical students, where he emphasised that the age of a patient was vital information to capture when carrying out patient studies.[481] In his own notes Duncan recorded the age of his patients in only around two thirds of cases.[482] Data given in the same figure for the Newcastle dispensary demonstrates that 8 per cent of patient admissions were aged 60 or above. By contrast, the proportion of aged individuals treated by the dispensary in Kelso was significantly higher than its Edinburgh or Newcastle counterparts, averaging 14 per cent.

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[477] Susannah R. Ottaway, *The Decline of Life: Old Age in Eighteenth-Century England* (Cambridge, 2004), pp.44-45.
[478] William Stark, *Practical Observations in Medicine by Andrew Duncan*, 1781 (DEP/DUA/1/28), p.9.
[479] *Practical Observations in Medicine by Andrew Duncan*, 1787 (DEP/DUA/1/42), p.68.
[480] Samantha Williams, 'Support for the Elderly During the 'Crisis' of the English Old Poor Law', in Chris Briggs, P. M. Kitson and S. J. Thompson (eds), *Population, Welfare and Economic Change in Britain 1290-1834* (Woodbridge, 2014), p.130; Ottaway, *The Decline of Life,* p.59.
[481] *Clinical Lectures of Andrew Duncan, Notes of Unidentified Student*, 1775-1776 (MS.2233), n.p.
[482] *Practical Observations in Medicine by Andrew Duncan*, 1779-1790 (DEP/DUA/1/20-47).

Contextualising these findings in relation to broader population statistics, using the same source material as previously considered in relation to children, approximately 8 per cent of the English population were over 60 years of age in the second half of the eighteenth century.[483] In the Scottish context, the 1755 and 1811 censuses again show significant consistency in the representation of this age group, with those aged 60 and upwards comprising 7.2 per cent of the overall total in both cases.[484] While accurate data is not available for the city of Edinburgh, the significant levels of migration of working-age individuals into the city in the later eighteenth century, make it likely that there were proportionately fewer aged individuals in Scotland's capital than is demonstrated by these censuses for the country as a whole.[485] For the town of Kelso, the information provided by Sinclair's statistical account demonstrates that 13.9 per cent of the population of the town was aged 50 or above in the final decade of the eighteenth century.[486] Unfortunately it is unclear what the impact has been on this figure of the lowering of the age bar by ten years.

Overall it appears that the town of Kelso contained a greater proportion of aged individuals than either Newcastle or Edinburgh in the later eighteenth century. This was primarily the result of Kelso, like many Scottish border towns, having experienced an exodus of able-bodied working-age individuals who were seeking employment elsewhere.[487] The age disparity within the local population was not significant enough, however, to account for the Kelso dispensary's admission of around double the proportion of aged individuals than either of the other dispensaries under discussion here. These findings must be further explored through an examination of the resources which were made available to the aged poor, both by the individual dispensaries and in the broader localities.

The town of Kelso, as previously discussed, differed from Edinburgh and Newcastle in a number of significant respects. Foremost, it lacked certain of the alternative resources for the aged poor which were available in those larger districts, particularly the workhouses. Similar to the historiographical findings relating to children, a range of studies have also emphasised the role of workhouses in their provision of support for the aged in the

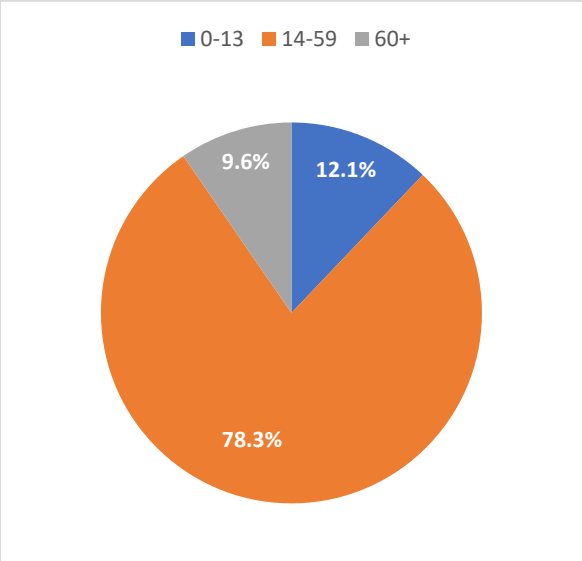
[483] Wrigley and Schofield, *The Population History of England,* p.216.
[484] Sinclair, *Analysis of the Statistical Account of Scotland, Volume One*, p.157.
[485] A. A. Lovett, I. D. Whyte and K. A. Whyte, 'Poisson Regression Analysis and Migration Fields: The Example of the Apprenticeship Records of Edinburgh in the Seventeenth and Eighteenth Centuries', *Transactions of the Institute of British Geographers*, 10:3 (1985), pp.317-331.
[486] Douglas, 'Parish of Kelso', p.586.
[487] The subject of Kelso's demographic changes is discussed in more detail in chapter one.

eighteenth century.[488] Correspondingly, almost a third of inmates in Newcastle's All Saints parish workhouse in 1780 were aged 60 or above.[489] While no equivalent data survives for the Edinburgh workhouses during this period, it is likely that they also played a significant role in housing the elderly.

The availability of such workhouse provision was not the only factor which could impact on dispensary admissions; the lack of a local infirmary in Kelso further exacerbated the need for the aged poor in that district to rely on dispensary provision. The extent to which infirmary care was accessible to the elderly can be difficult to discern. In the case of the Edinburgh and Newcastle infirmaries, stated policies regarding the admission of the aged took the form of disinclining the staff of those institutions from accepting them.[490] This was particularly emphasised in relation to those elderly individuals who were suffering from palsy, a broad term which referred to a range of conditions associated with loss of movement.[491] In cases where 'they cannot be expected to admit of a cure' they were disbarred from entry to both infirmaries.[492] The emphasis of both the Edinburgh and Newcastle infirmaries on the admission of acute, rather than chronic, cases might imply a bias against the admission of significant numbers of elderly patients into their care. However, while patient ages were not recorded in the admission registers of the Edinburgh infirmary, age-related data for the Newcastle infirmary demonstrates that it admitted a greater proportion of patients aged 60 or above than either the Edinburgh or Newcastle dispensaries (Figure 3.8).[493]

[488] See, for example, Samantha Williams, 'Support for the Elderly During the 'Crisis' of the English Old Poor Law', pp.139-142.
[489] *All Saints Parish Workhouse Admissions Book*, 1780 (TWA, 465/38).
[490] *A Code of Statutes and Rules for the Government of the Infirmary for the Counties of Newcastle Upon Tyne, Durham, and Northumberland*, p.24; Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1778), pp.88-89.
[491] Ibid.
[492] Ibid.
[493] There are, however, a number of surviving volumes of Edinburgh infirmary clinical lecture notes. Although there are no printed analyses of these volumes which provide a detailed breakdown of the ages of the patients they contain, the historian Guenter Risse studied these volumes and found that the average age of male admissions was 32.7 years, while the female average was 25.5 years. These do, however, comprise a limited sample of patient ages, recorded in only one of the infirmary's wards, the teaching ward. Risse, *Hospital life in Enlightenment Scotland*, p.87.

Figure 3.8. Age range of patients at the Newcastle infirmary, as a percentage of admissions where age is recorded, 1779-1787.[494]



Source: *Newcastle Infirmary Admission Registers*, 1779-1787 (TWA, HO.RVI/117/1-2).

It should not be assumed, however, that the Edinburgh and Newcastle dispensary rates of admission of the elderly, low even in comparison to the Newcastle infirmary, were based on any form of systematic exclusion. The formal policies of the individual dispensaries had only minimal impact; indeed, the Edinburgh and Kelso dispensaries made no mention of the treatment of the aged in their printed regulations. The Newcastle dispensary, although it did acknowledge that in cases of 'decay from age' that 'death be inevitable', did assert that 'humanity will prompt a Physician to contribute every aid from medicine, in order to alleviate the most painful symptoms'. [495] Although it did conclude this statement by asserting that one disadvantage in treating such elderly patients was that these particular 'sufferers, however, are always most importunate; and apt to complain'.[496]

Furthermore, the more vocal nature of elderly patients was not the only criticism levelled by the dispensaries who treated them. When Helen Donaldson, aged 66, was admitted to the Edinburgh dispensary in 1782 with a pimply eruption on her legs the treating physician recorded that, due to a combination of her age and poverty, he could not 'reasonably expect that cleanliness which [is] so essent[ial] to [her] cure'.[497] In this

[494] Detailed patient records for complete years are only available regarding the Newcastle infirmary for the period 1779-1787.
[495] Anon., *An Account of the Newcastle Dispensary, for the Relief of the Poor,* p.9.
[496] Ibid.
[497] *Practical Observations in Medicine by Andrew Duncan*, 1782 (DEP/DUA/1/29), p.65.

assessment, a patient's age not only impacted directly on their health, but also indirectly, through a reduction in their general hygiene and living standards. This was of particular consequence to the dispensaries because, by contrast to workhouses and infirmaries, in order for the aged to make use of dispensary care they needed to receive continued support elsewhere, possibly from outdoor poor relief, but perhaps more likely, from their kin. Dispensaries may have been able to treat such cases medically, but they did not provide the aged with food or shelter. Those elderly individuals who were too frail or sick to undertake employment and who lacked familial support systems would have faced difficulty in providing for themselves outside the walls of an institution.

The relationship between these different support systems for the elderly in the eighteenth century is a topic of historical debate. The historian Pat Thane has questioned the level of familial support available to the aged poor and has used the term 'nuclear hardship' to exemplify the notion that these individuals often received insufficient assistance from their families to meet their everyday needs.[498] She has further emphasised that the importance of poor relief in providing for the aged can be overstated.[499] By contrast, other historians have argued that, while poor relief was not guaranteed, in the case of the elderly and decrepit, they could largely rely upon their applications for relief being successful.[500] Ottaway, while not entirely discounting the roles of poor relief and kin in supporting the aged poor, has emphasised, rather, the relative independence and self-sufficiency of the elderly.[501] This independence is exemplified by individuals such as Wilson, discussed above, who continued to carry out paid employment when almost seventy years old.

The complex relationship between familial relief and institutional care in providing for the aged sick is illustrated by the case of Isobel Campbell, a widow, who left Edinburgh's Canongate Charity Workhouse in 1782 to travel to Norfolk to live with her daughter where, on arrival, she was taken ill with a fever.[502] Consequently, Campbell's daughter decided that

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[498] Pat Thane, *Old Age in English History: Past Experiences, Present Issues* (Oxford and New York, 2000), p.121.
[499] Pat Thane, 'Old People and Their Families in the English Past', in Martin Daunton (ed.), *Charity, Self-Interest and Welfare in the English Past* (London, 1996), p.113.
[500] Peter M. Solar, 'Poor Relief and English Economic Development Before the Industrial Revolution', *The Economic History Review*, 48:1 (1995), p.6; Samantha Williams, *Poverty, Gender and Life-Cycle Under the English Poor Law*, pp.102-103.
[501] Susannah R. Ottaway, 'Providing for the Elderly in Eighteenth-Century England', *Continuity and Change*, 13:3 (1998), pp.392-415.
[502] *Canongate Charity Workhouse Minute Book*, 24 December 1782 (ECA, SL11/1/1/6).

she was too much of a burden and sent her mother out of her home.[503] As a result, Campbell was 'reduced to great poverty and want' and so was readmitted to the Canongate workhouse.[504] For the aged poor, such as Campbell, kin may have been the preferred solution to their predicament but, when that resource failed, recourse could be made to the workhouse.[505] The Edinburgh dispensary, however, was not a practical option for Campbell, not because it would have refused to treat her, but rather because she didn't have the additional resources, both economic and social, which were necessary in order to make use of it.

3.5 Conclusion

It has been the aim of this chapter to demonstrate the role which the Edinburgh, Kelso, and Newcastle dispensaries played in increasing the resources available to the sick poor, not only by adding to the quantity of medical relief in each district, but by increasing the range of options available to them. The dispensaries allowed individuals greater opportunity to select the method of treatment which met their particular requirements. The ability for a patient to keep working or caring for their family while undertaking dispensary outpatient care was an important innovation. This was particularly relevant in the case of Edinburgh where infirmary outpatient treatment was not an option available to them.

Moreover, charitable medical institutions which pre-dated the existence of these dispensaries displayed significant biases which restricted access to their facilities to certain groups of society. This is particularly clear when considering the gender of patients, where the Edinburgh and Newcastle infirmaries displayed a consistent bias in favour of male admissions. While there were variations in the admission rates of female patients across the dispensaries studied here, women were, in all cases, significantly more likely to be admitted to those institutions than to the local infirmaries. The fact that the dispensaries were less

[503] Ibid.
[504] Ibid.
[505] Of course, not all elderly individuals were either able to or chose to access workhouse provision. For a more detailed discussion of the complexities of the role of the workhouses in the provision of relief to the elderly, see Jeremy Boulton and Leonard Schwarz, ' "The Comforts of a Private Fireside"? The Workhouse, the Elderly and the Poor Law in Georgian Westminster: St Martin-in-the-Fields, 1725-1824', in Joanne McEwan and Pamela Sharpe (eds), *Accommodating Poverty: The Housing and Living Arrangements of the English Poor, c.1600–1850* (Basingstoke, 2011), pp.221-240; Susannah Ottaway, 'The Elderly in the Eighteenth-Century Workhouse', in Jonathan Reinarz and Leonard Schwarz (eds), *Medicine and the Workhouse* (Rochester and Suffolk, 2013), pp.40-52.

bureaucratic in their admissions regulations also allowed individuals, including women, who commonly had fewer financial resources and who held less established positions in society, easier access to such provision.

The impact of the dispensaries on the medical treatment of children and the aged is more complex to assess. The picture here is less consistent, with the Kelso and Newcastle dispensaries showing relatively high levels of admission of these age groups, while the Edinburgh dispensary levels, by comparison, were significantly lower. These findings demonstrate the extent to which local circumstances, as well as dispensary admission procedures, impacted on admission rates, for the city of Edinburgh had a greater wealth of local resources for children and the elderly than either of the other districts. Moreover, the use of dispensary facilities, by both children and the elderly, were restricted, not by any exclusionary policies of the institutions themselves, but rather by external factors. Choice played a role by, in some cases, offering preferable alternatives, options which could supply accommodation and food in addition to medical treatment. Necessity, however, could be a more opportune term to describe the restrictions individuals faced in accessing dispensary care. If their additional needs were not supplied from another source, then the supply of medication alone would not have been sufficient charitable support for many. Furthermore, for individuals with long-term degenerative conditions associated with old age, the rehabilitative potential of the dispensaries or other medical relief was limited. In order to consider this subject in more detail, the following chapters will study approaches to such medical complaints, discussing the range of diseases which were admitted to dispensary care and the treatments which were provided. Before these subjects are entered into, however, the following chapter will uncover approaches which were adopted in the diagnosis of dispensary patients.

Chapter 4. Body and Mind: Changing Approaches to Medical Diagnosis

Medical diagnosis has a number of different components. First, it involves the understanding and employment by the individual physician of contemporary diagnostic terminology. This is only a single aspect, however. It must also involve the application of specific techniques to come to a particular diagnosis. These processes are far more nebulous. While eminent eighteenth-century physicians wrote extensively on the classification of disease, they were often much more reticent regarding the methods they used to come to these conclusions; methods, predominantly, of physical examination and verbal questioning. As a result, to a significant extent, individual physicians were reliant on their own experience and those of their colleagues to arrive at a diagnosis. Diagnostic techniques, therefore, could vary not just over time, but by geographical location and by individual practitioner. Standardisation, in knowledge, in approach and in the conclusions reached, cannot be assumed. Any bias of the practitioner, whether related to the social status or gender of the patient, or regarding the authority of a distinguished physician's latest published disease study, could be wrought on the body of the patient.

The disease classifications applied in the writings of eminent physicians have long been of interest to historians, with the eighteenth century often characterised as a period of significant development in disease theory.[506] Only more recently have the practical applications of these methods been discussed in more detail. Research, such as Roy and Dorothy Porter's *In Sickness and in Health*, on the British experience of illness between 1650 and 1850, moved beyond the diagnostic classifications detailed in printed medical texts to examine sources such as autobiographies and correspondence to uncover the lived experiences of patients.[507] Judith Walzer Leavitt, however, noted that this particular study focused on more wealthy and prominent patients, with the exclusion of the silent majority who did not keep detailed records of their own conditions.[508] The concern that a focus on

[506] R. R. Trail, 'Sydenham's Impact on English Medicine', *Medical History*, 9:4 (1965), pp.356-364; Esther Fischer-Homberger, 'Eighteenth-Century Nosology and its Survivors', *Medical History*, 14:4 (1970), pp.397-403.
[507] Roy Porter and Dorothy Porter, *In Sickness and in Health: The British Experience, 1650-1850* (London, 1988).
[508] Judith Walzer Leavitt, 'Medicine in Context: A Review Essay of the History of Medicine', *The American Historical Review*, 95:5 (1990), p.1477.

first-hand accounts weighs the historiography in favour of an educated minority is a recurring one in the writing on the subject.[509]

This is particularly significant when studying the late eighteenth and early nineteenth centuries because the process of diagnosis is characterised as not only having been under revision, but demonstrating a significant division of approach between the diagnosis of patients within private medical practice and poor patients who received charitable medical relief. Interest in the changes which took place in diagnostic approaches during this period was first sparked in the 1970s by the sociologist Nicholas Jewson who, in his examination of the patient's role within the medical encounter, identified a shift in the late eighteenth century from bedside medicine (where a paying patient was treated in their own home) to hospital medicine (where charitable patients were treated in public institutions).[510] Under this conceptualisation, a change was also apparent in the methods of diagnosis applied, with the former group being diagnosed primarily by methods of verbal examination, while in the case of the latter category the physical examination of the human body was the diagnostic technique most frequently applied.[511]

According to Jewson, the balance of power between the patient and the diagnosing physician was a significant factor in determining the method of diagnosis which was used.[512] When a patient was paying for a service, part of what they were buying was a measure of control over their own diagnosis and treatment.[513] Under infirmary care, the reverse was the case; physicians were able to control the medical encounter and were therefore able to choose their preferred diagnostic techniques.[514] Jewson's analysis, while subsequently critiqued by historians such as Anita Guerrini as too monolithic in approach, has stimulated considerable discussion on the role of the patient's voice in the clinical encounter.[515] More recent historical studies which will be discussed later in this chapter, including those of Risse and Fissell, have considered this subject in detail, using evidence from infirmary medical

[509] Lisa Wynne Smith, for example, notes the elite bias in focusing on medical consultation letters as a source for analysis of patients. Lisa Wynne Smith, ' "An Account of an Unaccountable Distemper": The Experience of Pain in Early Eighteenth-Century England and France', *Eighteenth-Century Studies*, 41:4 (2008), p.461.
[510] N. D. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870', *Sociology*, 10:2 (1976), pp.232-235.
[511] Ibid., pp.232-237.
[512] Ibid.
[513] Ibid.
[514] Ibid.
[515] Guerrini, ' "A Club of Little Villains": Rhetoric, Professional Identity and Medical Pamphlet Wars', p.227.

records to demonstrate how the social status of the patient could impact on diagnostic techniques in the later eighteenth century.

This chapter will contribute to this scholarship by considering a third category, neither bedside nor hospital, but rather dispensary outpatient care. Initially, it will look at the changing landscape of medical terminology during this period, considering the disconnect, where it exists, between the diagnostic terms detailed in printed works and the language used by dispensary physicians when diagnosing their patients. It will then examine the techniques which were utilised in the diagnosis of dispensary patients, from methods of physical examination of the patient's body to verbal diagnostic techniques. The next part of the chapter will investigate the reliability of such verbal techniques, and how suspicion could be placed upon the veracity of the dispensary patient's voice in the diagnostic process. Overall, this analysis will demonstrate the ways in which the distinctive circumstances of dispensary provision created an environment where the diagnosis of patients under the care of such institutions, while not entirely in isolation from contemporary innovations, could develop certain distinctive traits.

4.1 Classifying and Identifying Disease

'Regarding [the] disease of this patient [I] must own that… [I] am very much at [a] loss… [I am] so far from certainty that [I] could not even form [a] probab[le] conclus[ion]'.[516] This statement relates to the case of John Seaton, who was admitted into the Edinburgh dispensary in the summer of 1777 suffering primarily from a difficulty in discharging urine.[517] Similar quotes, however, which detail the difficulty practitioners faced in forming a diagnosis, can be plucked from many patient case notes from the later eighteenth century.[518] The diagnosis of dispensary patients could be a complex process, although the registers and annual reports of the Kelso and Newcastle dispensaries do not fully reflect this. In almost all admissions recorded in these documents the patient's medical diagnosis is noted using one or two word summaries of their condition.[519] The detailed case notes of the

[516] John Seaton, *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/14), pp.18-21.
[517] Ibid., pp.18-25.
[518] See, for example, Janet Brown, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/11), pp.20-30.
[519] *Kelso Dispensary Patient Registers*, 1780-1805 (HH71/7-8 and HH71/43); Anon., *Newcastle Dispensary Annual Reports* (Newcastle, 1780-1810).

Edinburgh dispensary, however, demonstrate the underlying difficulty of arriving at such, apparently conclusive, diagnoses.

Eighteenth-century medical theory was characterised by the development of numerous nosologies which attempted to identify and separate diseases into comprehensive medical classifications.[520] The origins of systematic disease classification are considered to lie with the seventeenth-century physician Thomas Sydenham, who organised diseases based on his analysis of their symptoms.[521] Sydenham's work was then considerably expanded and reinterpreted over the course of the eighteenth century. Successive, though not always compatible, systems of classification were developed by a number of individuals, among the most prominent being the French physician François Boissier de Sauvages de Lacroix, the Swedish botanist and physician Carl Linnaeus, and the Scottish physicians William Cullen and John Brown.[522] Linnaeus and Sauvages were in close contact during the development of their theories and shared certain features in their approach, both applying aspects of botanical classification as a basis for their nosologies, including the use of the terms order, genus, and class.[523] Cullen, by contrast, particularly focused on nervous conditions as a basis for his nosology, applying the concept of 'nerves' broadly, encompassing conditions such as asthma, diabetes, and rickets within his classification.[524] Cullen's pupil, John Brown, disagreed with the approach of his professor and developed his own medical system, termed Brunonianism, based on a notion of excitability, whereby diseases were classified into two broad categories, resulting from either over or under stimulation.[525]

The Edinburgh dispensary case notes highlight the resulting complexity inherent in diagnosing patients in a period of such rapidly changing medical understanding. These notes often take a dozen or more pages to analyse a patient's symptoms and ruminate on possible

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[520] For a more detailed description of these eighteenth-century medical theories, see Margaret DeLacy, 'Nosology, Mortality, and Disease Theory in the Eighteenth Century', *Journal of the History of Medicine and Allied Sciences*, 54:2 (1999), pp. 261-284.

[521] Ibid., pp.270-275.

[522] W. F. Bynum, 'Nosology', in W. F. Bynum and Roy Porter (eds), *Companion Encyclopedia of the History of Medicine, Volume One* (London and New York, 1997), pp.343-348.

[523] Volker Hess and J. Andrew Mendelsohn, 'Sauvages' Paperwork: How Disease Classification Arose from Scholarly Note-Taking', *Early Science and Medicine*, 19:5 (2014), pp.471-503.

[524] W. F. Bynum, 'Nosology', pp.346-347; William Cullen, *First Lines of the Practice of Physic, Volume Two* (Philadelphia, 1792), pp.67-424.

[525] Guenter Risse, 'The History of John Brown's Medical System in Germany During the Years 1790-1806' (Ph.D. diss., University of Chicago, 1971), pp.107-128.

diagnoses, discussing, then often discarding, various contemporary innovations in medical thought.[526] In the majority of cases no firm conclusion as to the patient's condition is reached and within the reflections of Duncan, the author of these case notes, 'much at [a] loss' is one of the most common phrases to be found.[527] The difference in diagnostic approaches between the dispensaries is apt to be partially due to the use of the Edinburgh dispensary, not only as a charitable medical body, but also as a teaching institute for medical students, a factor which would have encouraged greater rumination by Duncan on the complexities and nuances of patient diagnosis. In addition, the need for brevity in recording patient histories in an admissions register or printed annual report resulted in the omission of key information. In the Kelso and Newcastle dispensary records only rarely was a patient noted as having suffered from more than one complaint concurrently. Although the rationale behind this is not clearly stated, it seems likely that only the condition which was considered to be the most critical was noted. The potential impact which this has on historiographical studies is significant, with analysis of this data implying greater rates of infectious and venereal diseases by contrast to common but less severe and, most likely, less often recorded underlying conditions such as intestinal worms.[528]

At the Edinburgh dispensary, by contrast, the frequency with which individuals were found to be suffering from multiple complaints simultaneously, and the resulting complex array of medical symptoms, was often a key factor in the failure to provide a conclusive diagnosis. Clinical diagnosis was also closely interwoven, as touched upon in chapter three, with a patient's occupation, gender, and age. Other physical signifiers could also be considered relevant when diagnosing a patient. These included factors based on the principles of humoral theory, in which the body was considered to be composed of four humors, or fluids, which needed to be maintained in a balance to ensure health.[529] A patient's illness could be caused by an imbalance of these four humors, or by an

[526] References to 57 different medical theorists and physicians have been identified in the Edinburgh dispensary clinical notes, including discussions on the accuracy and usefulness of the works of the medical nosologists Sauvages and Cullen. See, for example, William Bailey, *Practical Observations in Medicine by Andrew Duncan*, 1782 (DEP/DUA/1/12), p.142; Janet Jardine, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/12), p.23.

[527] This comment can be found scattered throughout the notes, including May Taylor, *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/13), p.69.

[528] The breakdown of the diseases of dispensary patients, including the subject of intestinal worms, will be discussed in more detail in chapter five of this thesis.

[529] For a more detailed discussion on the principles of humoral theory see Owsei Temkin, *Galenism: Rise and Decline of a Medical Philosophy* (Ithaca and London, 1973).

accumulation of a particular corrupt or putrid humor in one organ or area of their body.[530] Under this theory, the balance of humors was considered to be connected to a range of attributes, including an individual's physical appearance and geographical location.[531]

Although this system was falling out of use by the late eighteenth century, being replaced by systems such as those of Linnaeus and Sauvages, its tenets were not entirely removed from contemporary diagnostics.[532] Scrofula, for example, a condition associated with tumorous and ulcerous growths, was considered by Duncan to be experienced particularly by those of 'light coloured hair, fine skin, fair & florid complex[ion]' rather than with those 'of black or dark coloured hair & more swarthy complexion'.[533] Use of these physical signifiers in the diagnosis of scrofula was not restricted to Duncan and was included in the writings of nosologists of the period, including Cullen.[534] Although the historian Kathryn Woods has discussed how physical attributes such as hair colour decreased in importance over the course of the century as factors in assessing a patient's medical condition, clearly they were not entirely removed from late eighteenth-century diagnostics.[535] Diagnosis in this period could, therefore, depend on physical characteristics as much as on medical symptoms.

The medical terms applied also depended, to a significant extent, on the individual physician's diagnostic preferences. In spite of the work undertaken during the eighteenth century by individuals such as Cullen to bring standardisation to this process, there continued to be appreciable variation between practitioners in the terminology they used. In the case of the Kelso dispensary, in one year, 1805, 105 separate medical terms were used to diagnose 463 patients.[536] Some of these terms, such as phthisis and consumption, were variably used to describe the same condition.[537] In addition, in many cases, such as

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[530] Michael Stolberg, 'Examining the Body, c.1500-1750', in Sarah Toulalan and Kate Fisher (eds), *The Routledge History of Sex and the Body, 1500 to Present* (Abingdon and New York, 2013), p.95.
[531] Sachiko Kusukawa, 'Medicine in Western Europe in 1500', in Peter Elmer (ed.), *The Healing Arts: Health, Disease and Society in Europe, 1500-1800* (Manchester, 2004), pp.4-11.
[532] A number of studies of eighteenth-century medical institutions have emphasised the continued presence of aspects of humoral theory in medical diagnostics and treatment. See, for example, Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol*, p.154; Guenter B. Risse,' Glimpses of a Hidden Burden: Hydatid Disease in Eighteenth-Century Scotland', *Bulletin of the History of Medicine*, 79:3 (2005), p.539.
[533] James Gibson, *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/27), p.143.
[534] Cullen, *First Lines of the Practice of Physic, Volume Two*, pp.382-383.
[535] Kathryn Woods, 'Dismembering Appearances: The Cultural Meaning of the Body and its Parts in Eighteenth-Century Understanding' (Ph.D. diss., University of Edinburgh, 2014), pp.146-154.
[536] *Kelso Dispensary Patient Register*, 1805 (HH71/43).
[537] Ibid.

diarrhoea, headache and suppression of urine, these diagnoses would be characterised as symptoms rather than diseases.[538] Identifying this discrepancy is not a case of retrospective diagnosis, however, as this issue did not go unrecognised by contemporaries, with Duncan, for example, highlighting the failure by some practitioners to distinguish between what comprised a disease and what comprised a symptom.[539]

Fissell has studied this changing medical landscape, highlighting the increasing use of clinical terminology, particularly Latin nomenclature, in the diagnosis of patients towards the end of the eighteenth century.[540] This process, however, was far from complete in the early nineteenth century and the Kelso dispensary continued to use colloquial terms such as debility and flooding as disease categories.[541] The contrast between the use of such diagnoses in the Kelso registers and the more clinical terminology found in the Edinburgh case notes demonstrates a divergence in medical knowledge and medical practice. Both the Edinburgh and Newcastle dispensaries, however, experienced particular advantages when pursuing their diagnostic work. Their founders, Duncan and Clark, as noted in chapter two, were engaged in active research, publishing on patient cases which they observed at their dispensaries. Both men were also members of local medical societies which met regularly to discuss developments in medical theory and practice.[542] While less is known about the academic interests of the Kelso dispensary staff, it seems likely that their geographical and academic disconnect from wider medical developments was a significant factor in their continued use of less clinically precise terminology.[543] Moreover, their university training

[538] Ibid.
[539] See, for example, Dan Forbes, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/11), p.1; Betty Brown, *Practical Observations in Medicine by Andrew Duncan,* 1776-1777 (DEP/DUA/1/12), p.57.
[540] Mary E. Fissell, 'The Disappearance of the Patient's Narrative and the Invention of Hospital Medicine', in Roger French and Andrew Wear (eds), *British Medicine in an Age of Reform* (London, 1991), p.103.
[541] *Kelso Dispensary Patient Register*, 1791-1810 (HH71/43). Debility was a general term applied to individuals regardless of their age or gender and, rather than identifying a particular disease, it signified a general state of physical weakness. Flooding, however, was a term synonymous with menorrhagia, or haemorrhaging from the uterus. See Robert Hooper, *Quincy's Lexicon-Medicum. A New Medical Dictionary; Containing an Explanation of the Terms in Anatomy, Physiology, Practice of Physic, Materia Medica, Chymistry, Pharmacy, Surgery, Midwifery, and the Various Branches of Natural Philosophy Connected With Medicine* (Philadelphia, 1817), p.486.
[542] For a discussion of Duncan's societal affiliations, see chapter two of this thesis. Clark was an active member of the Newcastle Upon Tyne Medical and Philosophical Society, and his involvement is detailed in the minutes of that society. *Minutes of the Newcastle upon Tyne Medical and Philosophical Society*, 1786-1795 (NUC, Hosp. Archives 15).
[543] The divergence between medical practices in rural and urban localities is discussed in a number of publications. See, for example, Helen M. Dingwall, 'Illness, Disease and Pain', in Elizabeth Foyster and

may have been less extensive than their city counterparts. Evidence, unfortunately, is lacking to corroborate these suggestions. While names can be found in the University of Edinburgh's medical student registers which correspond with the names of Kelso dispensary physicians, there is insufficient proof to demonstrate whether these were necessarily the same individuals.[544]

4.2 Physical Examination of the Patient

The process of diagnosis, of course, entailed more than just an understanding of the current medical nomenclature; it also required the study and analysis of a patient's symptoms. Clark, in one of his published works on fevers, wrote that 'accurate attentive observation, and collecting useful facts', rather than indulging 'imaginations in delusive and extravagant hypotheses', must be the basis of medical practice.[545] In actuality, however, physicians of the late eighteenth century rarely provided clues as to the practical side of their patient examinations.[546]

Andrew Duncan, however, is an exception to this. Duncan described his physical examination techniques in one of his printed lecture plans in which he detailed the 'principal functions' which a physician should observe in the diagnosis of their patients.[547] These were: pulse, heat, respiration, and excretions.[548] Indeed, Duncan often went into some detail regarding his analysis of his dispensary patients' secretions. Identifying the difference between pus and mucus was considered to be particularly key, as the former was considered to be an indication that the patient was suffering from phthisis, while the latter

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Christopher A. Whatley (eds), *A History of Everyday Life in Scotland, 1600 to 1800* (Edinburgh, 2010), pp.110-128; Irvine Loudon, *Medical Care and the General Practitioner, 1750-1850* (Oxford, 1986).

[544] Of the six physicians listed in the Kelso dispensary's annual reports between its foundation and 1810, the names of three of these, Christopher Douglas, Andrew Wilson, and James Bell, correspond with entries for medical students in the University of Edinburgh's matriculation registers in the late eighteenth and early nineteenth centuries. In the case of Bell, three separate individuals appear with that name. Anon., *Kelso Dispensary Annual Reports* (1778-1810); *University of Edinburgh Matriculation Albums*, 1762-1805 (UEC, IN1/ADS/STA/2).

[545] Clark, *Observations on Fevers, Especially Those of the Continued Type*, p.ix.

[546] The common omission by physicians of descriptions of their methods of physical examination is noted by Porter. Roy Porter, 'The Rise of Physical Examination', in W. F. Bynum and Roy Porter (eds), *Medicine and the Five Senses* (Cambridge, 1993), p.190.

[547] 'A Plan for Clinical Lectures', which is found within the *Clinical Lectures of Andrew Duncan, Notes of Unidentified Student*, 1776 (MS.2235), pp.6-7.

[548] Ibid.

was a symptom of less dangerous catarrhal complaints.[549] His diagnostic approach involved examining colour, taste, smell and, particularly, density, because mucus floated in water while pus did not.[550] Techniques such as these, involving the examination of excreta, taking of the pulse, and observing the respiration and heat of the patient, are features commonly identified by historians as diagnostic tools of eighteenth-century physicians and are often considered to be the limit of the physical examination which it was considered acceptable for a physician to undertake.[551]

The techniques available to eighteenth-century practitioners have been characterised by historians as being inhibited by contemporary notions of modesty and propriety, combined with ideas about the role of the physician, as Roy Porter put it, being that of 'a thinker not a toucher'.[552] Much has been written on the changing role of physical examination in the diagnostic work of physicians, with the eighteenth century commonly characterised as a period of reticence in this regard, by comparison with the more hands-on approach which developed over the course of the nineteenth century.[553] One oft-cited example is the failure in the 1770s of physicians to identify the abdominal cancer of the philosopher David Hume, his condition remaining undiagnosed until Hume was visited by a surgeon, John Hunter, who was more willing to perform a physical examination.[554]

Early modern ideas about the boundaries between the roles of the physician and surgeon established the principle that surgeons were not only responsible for surgical operations, but for the diseases, treatments and, by extension, diagnoses which were focused on the exterior of the body.[555] Physicians, by contrast, were responsible primarily for internal medicine and for diagnostic techniques which were focused on verbal, rather

[549] Janet McKenlie, *Practical Observations in Medicine by Andrew Duncan*, 1777-1778 (DEP/DUA/1/15), pp.164-167.
[550] Ibid.
[551] See, for example, Roy Porter, 'The Rise of Physical Examination', p.183.
[552] Roy Porter, 'The Rise of Physical Examination', p.185. For a discussion on the significance of morality and modesty in patient examinations, see Eve Keller, 'The Subject of Touch: Medical Authority in Early Modern Midwifery', in Elizabeth D. Harvey (ed.), *Sensible Flesh: On Touch in Early Modern Culture* (Philadelphia, 2003), pp.62-80. Risse has also considered the role of modesty in inhibiting physician's examination of female patient's genitalia at the Edinburgh infirmary. See Risse, *Mending Bodies, Saving Souls*, p.244.
[553] See, for example, Roy Porter, 'The Rise of Physical Examination', pp.179-197.
[554] Malcolm Nicolson, 'Examining the Body Since 1750', in Sarah Toulalan and Kate Fisher (eds), *The Routledge History of Sex and the Body, 1500 to Present* (Abingdon and New York, 2013), p.106; Roy Porter, 'The Rise of Physical Examination', pp.180-181.
[555] Roy Porter, 'The Rise of Physical Examination', pp.184-185.

than physical, examination.[556] Although such ideas regarding the demarcation between the separate professions began to break down over the course of the eighteenth century, there remained a pervasive notion that the physical examination of patients was the role of the surgeon.[557] While in the closing decades of the century certain prominent physicians, including Matthew Baillie, nephew of the celebrated surgeon William Hunter, began to adopt diagnostic techniques based on those of their surgeon colleagues, these adaptations continued to prove controversial among many of their peers.[558]

The historian Malcolm Nicolson, however, has warned against an oversimplified interpretation of the role of physical examination in the diagnostics of eighteenth-century physicians.[559] Nicolson provides an example of a physician he has identified who physically examined venereal patients, both male and female, and emphasises that any attempt to imply standardisation of medical examination techniques does not take into account individual preference or varying social and intellectual contexts.[560] Indeed, Nicolson himself, in a separate article, has studied the unwillingness of Andrew Duncan junior, the son of the Edinburgh dispensary founder, in the early nineteenth century, to apply percussive techniques which had been developed in the 1750s by the Austrian physician Leopold Auenbrugger.[561] Evidence exists, however, in the Edinburgh dispensary case notes which demonstrates that Duncan senior was using these very same techniques over 30 years previously.[562] For example, when diagnosing the Edinburgh dispensary patient Frances Clerk in the winter of 1777, Duncan recorded that 'such [is] her real or pretended modesty that [she] will not submit to [an] accur[ate] exam[ination]', by either 'being sounded' by percussive methods or by 'draw[ing] water by catheter'.[563] While, in this instance, physical examination is identified only by its absence, this detailing of Clerk's unwillingness to be

[556] Ibid.
[557] Stolberg, 'Examining the Body', pp.91-92.
[558] Nenadic, 'Writing Medical Lives, Creating Posthumous Reputations', pp.523-524.
[559] Nicolson, 'Examining the Body Since 1750', pp.106-108.
[560] Ibid., pp.106-107. Michael Stolberg has made similar observations regarding medical techniques in the early modern period, demonstrating a range of applications of physical examination in this period. See Stolberg, 'Examining the Body', pp.93-101.
[561] Malcolm Nicolson, 'The Introduction of Percussion and Stethoscopy to Early Nineteenth-Century Edinburgh', in W. F. Bynum and Roy Porter (eds), *Medicine and the Five Senses* (Cambridge, 1993), pp.135-139.
[562] Duncan noted the use of percussion on a number of his patients, including Robert MacDonald, *Practical Observations in Medicine by Andrew Duncan*, 1780 (DEP/DUA/1/23), p.129; William Campbell, *Practical Observations in Medicine by Andrew Duncan*, 1785 (DEP/DUA/1/37), p.285.
[563] *Practical Observations in Medicine by Andrew Duncan*, 1777-1778 (DEP/DUA/1/16), p.116.

examined by such methods certainly implies that these were routine diagnostic techniques, techniques which were sufficiently commonplace to be considered worth mentioning only when a patient refused to submit to them.

Nicolson has argued that historians should be cautious of the disconnect between intellectual theorising in print and the techniques which were put into practical use by physicians, emphasising that theoretical approaches would often be detailed significantly in advance of their becoming part of common medical practice.[564] In the case of the Edinburgh dispensary, however, the opposite seems to be the case. In spite of Duncan's mention in his handwritten notes of the use of percussion and, in another example from 1776, noting that he identified a tumour in a female patient's breast by touch, there is no mention of such techniques in his printed works during this period.[565] The possibility that the Edinburgh dispensary was undertaking procedures which were in advance of those in use elsewhere should not be ignored. Historians, including Helen Dingwall, have emphasised Edinburgh's place in the eighteenth century at the epicentre of medical innovation.[566] The Edinburgh dispensary would have been no exception to this and its role as a teaching institution further encouraged the use of experimental diagnostic techniques. Unfortunately, there is no scope for comparison with the Kelso and Newcastle dispensaries in this regard as the tabular data recorded in their admission registers and annual reports lack detail regarding the processes which their physicians used to reach their diagnoses.

4.3 Verbal Examination of the Patient

A further potential resource which could aid the physician in their diagnosis was the patient's own narrative. This was a key component of humoral theory, under which factors such as the individual's temperament and lifestyle were taken into consideration in the diagnostic process. For example, when the French physician Jacques Ferrand wrote on the diagnosis of 'erotic melancholy' in the seventeenth century, he emphasised the importance of studying a patient's dreams for they delivered 'knowledge of the Humour that doth

[564] Nicolson, 'The Introduction of Percussion and Stethoscopy', p.135.
[565] The tumor case was a patient by the name of Mary Dods. See *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/12), pp.13-19.
[566] Dingwall, 'Illness, Disease and Pain', pp.110-111.

predominate' and demonstrated 'the disposition of the Body'.[567] There is a lack of clarity, however, regarding the extent to which this diagnostic tool remained in use by the late eighteenth century.[568]

Fissell has argued that, towards the end of the eighteenth century, diagnoses increasingly focused on the anatomy of the sick body rather than on the patient as an individual, whose thoughts and opinions could assist the physician's understanding of their complaint.[569] Indeed, Fissell goes as far as to state that 'the patient's narrative of illness was made utterly redundant' by this more clinical approach to patient treatment.[570] Risse has similarly asserted that physicians, over the course of the eighteenth century, increased their use of physical examination techniques, partially as a replacement for relying on the patient's own description of their condition.[571] Risse, like Fissell and Jewson, views this change as due, in part, to the expanding remit of physicians, with their medical work increasingly encompassing the sick poor who visited charitable institutions.

To characterise the mistrust of charitable patients as necessarily resulting in a move from verbal to physical diagnostic techniques, however, would be an oversimplification. Firstly, the weight given to the narrative of the wealthy patient can be questioned. The case of Cullen, who provided mail-order treatment in his private practice, is argued by historians such as Roy Porter to demonstrate how physicians, when treating their wealthier clients, were reliant for their diagnosis on the accuracy of their patient's written testimonies.[572] In practice, though, a significant proportion of this correspondence was conducted with the patient's local doctor rather than with patients themselves.[573] In these cases the patient's physician would carry out their examination before detailing their findings in writing to

[567] James Ferrand, *Erōtomania or a Treatise Discoursing of the Essence, Causes, Symptomes, Prognosticks, and Cure of Love, or Erotique Melancholy* (Oxford, 1640), pp.178-185.
[568] For a more detailed discussion of this subject, see Johanna Geyer-Kordesch, 'Whose Enlightenment? Medicine, Witchcraft, Melancholia and Pathology', in Roy Porter (ed.), *Medicine in the Enlightenment* (Amsterdam, 1995), pp.113-125.
[569] Fissell, 'The Disappearance of the Patient's Narrative', pp.93-103.
[570] Ibid., p.93.
[571] For a discussion of the suspicions of charity physicians towards their patients, see Risse, *Hospital Life in Enlightenment Scotland*, pp.108-113.
[572] Roy Porter, 'The Rise of Physical Examination', p.183.
[573] Examples of Cullen corresponding with physicians, rather than directly with their patients, can be found scattered throughout his consultation letters. See, for example, John Stevenson, *Correspondence of William Cullen*, 4 April 1777 (DEP/CUL/1/2/488); John Mudie, 1 April 1778 (DEP/CUL/1/2/600a).

Cullen. Trust, therefore, was often placed in the testimony of a medical professional, rather than the patient's own self-diagnosis.

In addition, changes in medical theory, from the earlier humoral system to those based on scientific principles, placed less importance on the patient's character and temperament than had previously been the case. The social class of the patient was not the only causal factor in the shift from verbal to physical examinations, but also the changing medical theory which underpinned it. Furthermore, the extent of this change in diagnostic approach should not be overstated. Risse and Fissell's findings were based primarily on their research into, respectively, the Edinburgh and Bristol infirmaries. Inpatient infirmary treatment allowed for significant control over the patient. Their diet, their hygiene, and the range of medicaments which they took could all be closely regulated within this environment and the patient's symptoms could be closely observed. The power in such institutions lay primarily with the medical practitioner. Those wealthy patients whose only interaction with a physician was via written consultation, and who may have never met their diagnosing physician in person, comprise the other extreme of the treatment process in the later eighteenth century.

The dispensary, however, provided a middle-ground between these two approaches. The work of Jewson and Fissell has emphasised the importance of the physical location of the encounter between the physician and the patient, using examples where poor patients were removed from their homes and families and placed in institutional care. By contrast, while the dispensary physician would meet, examine, and diagnose their patient, they had little control over their everyday lives and the observation of a patient's symptoms was limited to brief consultations. The patient's narrative was, therefore, by necessity, an essential component of dispensary diagnosis. Indeed, Duncan, in his dispensary lecture plans in the later eighteenth century emphasised to his students the importance of recording the 'Feelings of the patient' and 'The patient's conjectures' regarding the cause of their complaint.[574]

[574] 'A Plan for Clinical Lectures', *Clinical Lectures of Andrew Duncan, Notes of Unidentified Student*, 1776 (MS.2235), pp.6-7.

4.4 The Patient's Narrative

The question of the accuracy of the patient's narrative stretched beyond a concern as to their ability to clearly describe their symptoms. With the expansion of access to charitable healthcare in the eighteenth century came misgivings as to the motives of some of those seeking treatment. While discussions on the suspected misuse of infirmaries and poor relief have been discussed in chapter one, abuse of dispensary services received much less attention in contemporary scholarly papers and printed tracts. Indeed, the justifications given for the establishment of dispensaries often emphasised that, by their very nature, they were far less prone to abuse than infirmaries, as they commonly did not provide those who were admitted into their care with either accommodation or food.[575] In spite of this, the possibility that individuals would falsify a medical condition was not entirely absent and, although not widely publicised by the institutions, the suspicion that individuals could attempt to gain admission under false pretences still remained. This section of the chapter will investigate the concerns of these institutions and their staff, with a particular focus on the subjects of pregnancy and hysteria, the two categories of admissions which were considered particularly prone to fabrication.

While little can be gleaned from the Kelso and Newcastle dispensary annual reports regarding any doubts which their medical staff may have held, the more detailed records of the Edinburgh dispensary provide insight into the suspicions of dispensary staff. The diagnosis of Mary McDonald provides one such example. McDonald visited the Edinburgh dispensary in the winter of 1780 in an attempt to gain admission.[576] In her consultation with the medical staff there the afflictions she detailed were extensive, ranging from stomach swelling and constipation to vomiting, headaches, hot and cold fits, impaired appetite, and impeded menstruation.[577] Indeed, according to Duncan, McDonald 'seems disp[osed] to tell [us] that [she] has every sympt[om] which [is] ment[ioned] to her'.[578] In considering whether McDonald's condition was 'entir[e]ly a fiction', Duncan gave no clear basis for his suspicions, but observed that 'were this woman my patient in [a] hospit[al] where [she

[575] Duncan, *Observations on a Proposal for Establishing at Edinburgh a Public Dispensary,* p.43.
[576] *Practical Observations in Medicine by Andrew Duncan*, 1780 (DEP/DUA/1/24), pp.116-136.
[577] Ibid.
[578] Ibid., p.122.

would] obt[ain] comfort food & lodging in conseq[ence] of [her] disease [I] should be inclin[e]d to this suppos[ition]'.[579]

When Duncan registered doubt as to the accuracy of details given to him by his patients, his doubt occurred most frequently with female patients and particularly, as in the case of McDonald, in relation to the diagnosis of conditions relating to impeded menstruation. However, identifying anomalies in cases of gynaecological complications was particularly challenging given the frequency with which such symptoms arose and the relative lack of knowledge of their causes. While the paucity of information on patient symptoms in the tabular records of the Kelso and Newcastle dispensaries serves to disguise the extent of the complications which resulted from such conditions, the more detailed narrative records of the Edinburgh dispensary demonstrate the frequency with which issues relating to a female patient's reproductive organs could play a part in their seeking dispensary treatment.

Over a third of the recorded cases of female patients at the Edinburgh dispensary involved symptoms relating to issues of this nature, including either irregular or excessive menstruation.[580] In other cases, such as that of 40 year old Isabel Campbell, who was admitted to the dispensary in January 1790, detailed symptoms included *fluor albus* (a form of vaginal discharge, also known as 'the whites').[581] Campbell was described as suffering from a 'constant discharge from the vagina of a considerable quantity of thick viscid, whitish coloured matter'.[582] Complications such as these were detailed even in cases where the final diagnosis given was not clearly related to these symptoms, including cases of rheumatism and catarrh.[583] In some instances either haemorrhaging or amenorrhoea (the total cessation of menstruation) was experienced for a number of years before the patient sought admission, demonstrating how, for some women, these conditions were treated as a commonplace aspect of everyday life.[584]

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[579] Ibid.
[580] *Practical Observations in Medicine by Andrew Duncan*, 1777-1790 (DEP/DUA/1/11-47).
[581] *Practical Observations in Medicine by Andrew Duncan*, 1790 (DEP/DUA/1/47), n.p.
[582] Ibid.
[583] Elizabeth Gray, *Practical Observations in Medicine by Andrew Duncan*, 1778-1779 (DEP/DUA/1/19), pp.85-97; Mary Lamb, *Practical Observations in Medicine by Andrew Duncan*, 1783 (DEP/DUA/1/32), pp.93-102.
[584] Examples of this can be found through the dispensary case notes, including Tibby Green, *Practical Observations in Medicine by Andrew Duncan*, 1783 (DEP/DUA/1/32), pp.236-237; Janet Frazer, *Practical Observations in Medicine by Andrew Duncan*, 1787 (DEP/DUA/1/43), pp.28-31.

For other patients, cases of obstructed menses could serve to disguise another condition, pregnancy, which lead to a recurring concern, how could a medical practitioner accurately identify when their patient was pregnant? Duncan himself, in his published lectures on the subject of medical jurisprudence, wrote that identification of the condition could often be uncertain until the sixth or seventh month of pregnancy.[585] This could particularly be the case with those women who were poor and malnourished. Historical medical understanding of the relationship between an individual's weight, poor nutrition, and infertility has been considered by the historian Sarah Toulalan in a study relating primarily to early modern England.[586] According to Toulalan's findings, while the exact role of menstrual blood in the process of procreation was still a subject of debate amongst medical practitioners in the seventeenth and eighteenth centuries, the negative affect of an unusually low body weight on menstruation and, by extension, on fertility was widely attested to.[587] Lack of menstruation, therefore, could not always be used as an accurate method of identification of pregnancy. Neither, it appears, could the testimony of the patients themselves.

This issue was considered particularly pertinent when prescribing certain types of medicaments. Duncan registered concern on a number of occasions that patients may have been disguising their pregnancy and falsifying a separate medical condition in an attempt to procure treatment that would bring about the 'restor[ation] of mens[truation] [and] abort[ion] [would thereby be] prod[uced]'.[588] One solution which Duncan undertook was to refrain from the more invasive purgatives until enough time had passed for the pregnancy, if it existed, to become clearly visible on the woman's body.[589] Yet determining this could be further complicated by complaints such as ovarian dropsy which, as the historian Sally

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[585] Andrew Duncan, *Heads of Lectures on Medical Jurisprudence or the Institutiones Medicinae Legalis* (Edinburgh, 1792), p.12. For a more detailed discussion of the difficulty in identifying pregnancy in the early modern period and into the eighteenth century, see Cathy McClive, 'The Hidden Truths of the Belly: The Uncertainties of Pregnancy in Early Modern Europe', *Social History of Medicine*, 15:2 (2002), pp.209-227.
[586] Sarah Toulalan, ' "If slendernesse be the cause of unfruitfulnesse; you must nourish and fatten the body": Thin Bodies and Infertility in Early Modern England', in Gayle Davis and Tracey Loughran (eds), *The Palgrave Handbook of Infertility in History: Approaches, Contexts and Perspectives* (London, 2017), pp.171-190.
[587] Ibid., pp.179-181.
[588] The example quoted here is from the case of Tibby Deacon, but other entries where this issue was raised can be found scattered throughout the dispensary notes, including those of Barbara Sinclair and Agnes Mitchell. See *Practical Observations in Medicine by Andrew Duncan*, 10 November 1786 (DEP/DUA/1/40), pp.184-n.p.; *Practical Observations in Medicine by Andrew Duncan*, 1789 (DEP/DUA/1/45), pp.164-169; *Practical Observations in Medicine by Andrew Duncan*, 1786-1787 (DEP/DUA/1/40), pp.18-19.
[589] Kath Duff, *Practical Observations in Medicine by Andrew Duncan*, 1780-1781 (DEP/DUA/1/25), pp.11-19.

Frampton has demonstrated, caused swellings of the stomach that could give the appearance of pregnancy.[590] Indeed, whether attempts to procure abortions occurred as frequently in reality as Duncan's suspicions imply is unclear, although Risse has identified similar concerns among physicians at the Edinburgh infirmary during this period.[591]

Interest in the history of infanticide has grown in recent decades. It is a subject which has been considered in its English context particularly in relation to resulting legal proceedings, with court records being a key source.[592] Scottish studies, by contrast, although acknowledging the diminishing influence of the church during the eighteenth century, often emphasise the importance of kirk sessions in the monitoring and punishment of the perpetrators.[593] While the subject of abortion has received much less attention in scholarly literature than infanticide, examples of seventeenth- and eighteenth-century attempts to procure abortifacients have been identified.[594] These herbal treatments, however, commonly served a dual purpose; they could be used either to terminate a pregnancy, or to encourage bleeding in a fashion which was thought to promote fertility.[595] The euphemistic terminology used in the advertising of such medicines, their usefulness for the removal of 'female obstructions', further obfuscates the matter.[596] The purpose, in individual instances, for which a particular medicine was taken is open to significant interpretation.

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[590] Sally Frampton, 'The Debris of Life: Diseases Ovaries in Eighteenth-Century Medicine', in Raymond Stephanson and Darren N. Wagner (eds), *The Secrets of Generation: Reproduction in the Long Eighteenth Century* (Toronto, Buffalo and London, 2015), pp.344-359.

[591] Risse, 'Hysteria at the Edinburgh Infirmary', pp.17-21.

[592] See, for example, Garthine Walker, *Crime, Gender and Social Order in Early Modern England* (Cambridge and New York, 2003), pp.148-158; Dana Rabin, 'Bodies of Evidence, States of Mind: Infanticide, Emotion and Sensibility in Eighteenth-Century England', in Mark Jackson (ed.), *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000* (Aldershot and Burlington, 2002), pp.73-92.

[593] Anne-Marie Kilday, ' "Monsters of the Vilest Kind": Infanticidal Women and Attitudes to their Criminality in Eighteenth-Century Scotland', *Family & Community History*, 11:2 (2008), pp.100-112; Deborah A. Symonds, *Weep Not for Me: Women, Ballads, and Infanticide in Early Modern Scotland* (Pennsylvania, 1997), p.72.

[594] Lynn Abrams, 'From Demon to Victim: The Infanticidal Mother in Shetland, 1699-1899', in Yvonne Galloway Brown and Rona Ferguson (eds), *Twisted Sisters: Women, Crime and Deviance in Scotland Since 1400* (East Linton, 2002), p.183; Leah Leneman and Rosalind Mitchison, *Sin in the City: Sexuality and Social Control in Urban Scotland, 1660-1780* (Edinburgh, 1998), pp.54-56.

[595] Jennifer Evans has discussed the subject in greater detail in her study of fertility in early modern England. Jennifer Evans, *Aphrodisiacs, Fertility and Medicine in Early Modern England* (Woodbridge and Rochester, 2014), pp.160-164.

[596] See, for example, advertisements for 'Welch's Pills', *The Ipswich Journal*, 1 August 1789, p.1 and 'Pullin's Female Pills', *The Northampton Mercury*, 13 July 1799, p.4.

Anne-Marie Kilday, in a study of women and violent crime in Scotland during the Enlightenment, has argued that women were more likely to undertake infanticide than abortion, this having been due, in large part, to the relative danger to the health of the mother of undertaking an invasive procedure.[597] While the dangers inherent in abortion in this period cannot be denied, it must be acknowledged both that childbirth itself was hardly without danger and, also, that lack of evidence of abortion cannot be taken as proof of its absence.[598] Abortion would certainly have commonly left less evidence and have been less likely to come to the attention of the authorities than the killing of a new-born child. Studies which rely on legal or kirk records will, inevitably, focus particularly on those individuals who were formally suspected, even if not convicted, of such a crime.

While the cases identified here cannot definitively prove the frequency with which female patients attempted to seek admission to a dispensary under false pretences with the intention of procuring an abortion, they do provide insight into a wider concern by medical practitioners about instances of abortion that lies outside the scope of studies which focus on legal and religious sources. This is particularly the case when individual physicians, such as Duncan, do not appear to have reported their concerns to any legal or church authorities. Suspicion may have been commonplace, but proof of intent, as Duncan demonstrates, was difficult to come by.

The other condition which was considered particularly prone to falsification was that of hysteria. Removed from its earlier association, primarily, with complications of the womb, by the later eighteenth century hysteria was commonly categorised, rather, as a nervous disorder.[599] While the notion that, in this period, hysteria was more commonly a complaint that afflicted wealthier members of society still continues to linger in many studies of the condition, some historians have begun to acknowledge its existence in less privileged

[597] Anne-Marie Kilday, *Women and Violent Crime in Enlightenment Scotland* (Woodbridge and Rochester, 2007), p.73.

[598] For more detailed discussions of maternal mortality in the late eighteenth and early nineteenth centuries, see Lisa Forman Cody, *Birthing the Nation: Sex, Science, and the Conception of Eighteenth-Century Britons* (Oxford, 2005); Irvine Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality, 1800-1950* (Oxford, 1992).

[599] For a detailed study of the historical development of medical understanding of hysteria, see G. S. Rousseau, ' "A Strange Pathology": Hysteria in the Early Modern World, 1500-1800', in Sander L. Gilman, Helen King, Roy Porter, G. S. Rousseau and Elaine Showalter (eds), *Hysteria Beyond Freud* (Berkeley, Los Angeles and London, 1993), pp.91-186.

circles.[600] Little detailed analysis, however, has been carried out on hysteria amongst members of the working population in the eighteenth century, with the exception of the work of Risse regarding patients at the Edinburgh infirmary.[601]

Symptoms of hysteria were considered to be wide-ranging, from fits to emotional distress, dizziness, paralysis, constipation, difficulty breathing, and depression.[602] While fits are one of the symptoms most commonly associated with hysteria in the secondary literature, in his study, Risse noted that many patients diagnosed with hysteria did not display this particular symptom.[603] Contemporary sources, however, such as the writings of the physician William Cullen, characterised fits as the key symptom in identifying cases of hysteria.[604] Duncan, in his diagnosis of Edinburgh dispensary patients, navigated this apparent contradiction by separating cases of hysteria into two distinct categories: hysteria fits and hysteria symptoms.[605] Those suffering from the latter showed many of the hallmark symptoms of hysteria previously mentioned, but were not subject to attendant fits.

This ambiguity in the diagnosis of a nervous condition which presented few clear-cut symptoms appears to be one of the primary reasons why many contemporary physicians considered it particularly prone to falsification. In the identification of this disorder the dispensary physician was especially reliant on the testimony of their patients as they were unlikely to witness their symptoms first-hand. Duncan noted on a number of occasions, such as in the case of 29 year old Mary Rawlinson who was admitted to the Edinburgh dispensary in the spring of 1782, that although the symptoms which were described 'might in some degree exist' that he 'yet had reason to pres[ume] that [they] were to no great degree &

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[600] Roy Porter, for example, described hysteria as a condition which, in the eighteenth century, circulated particularly amongst the wealthy. See Roy Porter, 'The Body and the Mind, The Doctor and the Patient: Negotiating Hysteria', in Sander L. Gilman, Helen King, Roy Porter, G. S. Rousseau and Elaine Showalter (eds), *Hysteria Beyond Freud* (Berkeley, Los Angeles and London, 1993), p.227. Andrew Scull, similarly, associated the condition with 'the moneyed the fashionable crowd'. See Andrew Scull, *Hysteria: The Biography* (Oxford, 2009), pp.41-42. For an example of a study which highlights the existence of hysteria among the less well off, although not studying it in detail, see Heather Meek, 'Of Wandering Wombs and Wrongs of Women: Evolving Conceptions of Hysteria in the Age of Reason', *English Studies in Canada*, 35:2/3 (2009), pp.105-125.

[601] Risse, 'Hysteria at the Edinburgh Infirmary', pp.1-22.

[602] George Wallis, *The Art of Preventing Diseases and Restoring Health, Founded on Rational Principles and Adapted to Persons of Every Capacity* (London, 1796), pp.704-707; Cullen*, First Lines of the Practice of Physic, Volume Two,* pp.257-263.

[603] Risse, 'Hysteria at the Edinburgh Infirmary', pp.9-10.

[604] Cullen*, First Lines of the Practice of Physic, Volume Two,* p.257.

[605] Indeed, Duncan stated that cases of hysteria symptoms were significantly more common than those of hysteria fits. See Binny Robinson, *Practical Observations in Medicine by Andrew Duncan*, 1780 (DEP/DUA/1/26), pp.53-54.

that [the] patient[’s] repres[entation] of [the] affect [is] rather exaggerated’.[606] Duncan went even further in another case, arguing that ‘hyster[ia] symp[toms] [are] often feign[e]d… many female[s]… [are] not only capab[le] of very exact imit[ation] of fits but even of induc[ing] real fits when necess[ary]’.[607] While hysteria was recognised as a legitimate condition, a disorder worthy of medical study and treatment, this did not negate, in the eyes of physicians, the possibility that many individual instances of it were fabricated.

The rationale as to why a female dispensary patient would falsify the condition of hysteria when there was no obvious return in doing so is not clear. In some instances the possible fabrication was associated with attempts to procure abortions. In broader terms, some historians, including Mark Micale, have posited the notion of hysteria as a form of protest by the powerless.[608] Under this analysis, individuals who lacked the outlets of education and professional employment, which were available to many of their male counterparts, may have, unconsciously, acted out hysterical symptoms to gain attention or recognition.[609] However, Micale questions the extent to which this form of expression was likely to manifest among less well-off individuals, postulating that it was likely to have been more commonly a phenomenon among the bourgeoisie.[610]

Moreover, while this motivation cannot be entirely ruled out in the context of dispensary patients, whether those whose testimonials were considered suspicious were actually fabricating their condition cannot easily be determined. In the examples of both hysteria and suspected attempted abortion considered here, the evidence which survives demonstrates the suspicion of the physician rather than the guilt of the patient. In a period where symptoms were often vague, diagnoses difficult and physical examination rare, the challenge of trusting the words of the patient was paramount in deciding the authenticity of a complaint. The general debility witnessed in many patients, made particularly clear in female patients with their frequent gynaecological complaints, points to a general poor state of health not easily diagnosed or treatable. Suspicions of the falsification by patients of their symptoms appear to result more from medical ambiguity than from evidence of intent.

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[606] *Practical Observations in Medicine by Andrew Duncan*, 1782 (DEP/DUA/1/29), p.120.
[607] Betty Smart, *Practical Observations in Medicine by Andrew Duncan*, 1783 (DEP/DUA/1/30), p.190.
[608] Mark S. Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton and Chichester, 1995), p.158.
[609] Ibid.
[610] Ibid.

4.5 Conclusion

This chapter has argued that medical diagnosis in the late eighteenth and early nineteenth centuries demonstrates a significant divergence between apparently increasingly robust clinical terminology and the ability of the physician, in practice, to apply such diagnoses. In addition, the increase in infirmary-based medical treatment, in combination with factors such as changing understanding of disease causation, impacted on methods of diagnosis. This primarily took the form of the increased employment of methods of physical examination and the systematic monitoring of patients being treated under an inpatient system. Challenges, on the part of the individual physician, in arriving at a diagnosis, however, remained. Indeed, the increased access of the poor to orthodox medical practitioners via charitable relief systems raised particular problems, including the diagnostic difficulties posed by symptoms of malnutrition.

The perceptions of the physician in relation to their poorer patients have also been considered. This includes doubt as to their patient's ability to accurately describe their symptoms and, in some cases, even suspicion that they may have been intentionally trying to deceive their diagnosing physician. The distinctive nature of dispensary practice, however, did not allow for the systems of monitoring and levels of control over patients which infirmaries were able to put in place. As a result, while clinical terminology and diagnostic techniques were experiencing a period of change, for dispensaries, the patient's voice remained an important component of the diagnostic process. While this did not remove, entirely, mistrust on the part of the practitioner in certain instances, overall, the patient's narrative, by necessity, continued to be an essential component of dispensary diagnosis.

Chapter 5. Diseases, Conditions, Disorders, and Complaints

As chapter four revealed, disease classification underwent considerable review and revision over the course of the eighteenth century. Moreover, the understanding of what comprised an individual disease was often fluid. Measles were thought to cause intestinal worms.[611] Smallpox could cause leprosy.[612] The boundaries between conditions which, in the twenty-first century, would be considered immutable were viewed as porous. It was not only the diseased state which could alter. Language was often inconsistent. The term scurvy, now identified as a disease associated with vitamin C deficiency, in the eighteenth century had a range of meanings. In his clinical lectures Andrew Duncan bemoaned that as well as being applied to the condition also known as sea scurvy, a wide array of skin complaints were 'known among [the] vulg[ar] und[e]r [the] vague term of scurvy'.[613] Over the course of the nineteenth century the greater use of post mortems, combined with advances in technologies such as microscopy, enabled a more detailed understanding of a range of complaints.[614]

The analysis of disease in the late eighteenth and early nineteenth centuries, therefore, must consider these diseases not as fixed concepts, but as changing entities. Indeed, Charles Rosenberg, writing in the 1980s, argued that disease 'is at once a biological event', a collection of 'verbal constructs… an aspect of and potential legitimation for public policy, a potentially defining element of social role, a sanction for cultural norms, and a structuring element in doctor / patent interactions'.[615] Rosenberg's approach has since become an established method of interpreting the history of disease, with historians such as Mark Jackson focusing particularly on the significance of contemporary societal expectations in determining how diseases were understood.[616]

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[611] Risse, *Hospital Life in Enlightenment Scotland*, p.150.
[612] Ann Saunders, *Practical Observations in Medicine by Andrew Duncan*, 1782-1783 (DEP/DUA/1/30), pp.26-49.
[613] Christian Watt, *Practical Observations in Medicine by Andrew Duncan*, 1779-1780 (DEP/DUA/1/21), p.40.
[614] Russell C. Maulitz, 'The Pathological Tradition', in W. F. Bynum and Roy Porter (eds), *Companion Encyclopedia of the History of Medicine, Volume One* (London and New York, 1997), pp.169-189.
[615] Charles E. Rosenberg, 'Disease in History: Frames and Framers', *The Milbank Quarterly*, 67:1 (1989), p.1.
[616] Mark Jackson, 'Perspectives on the History of Disease', in Mark Jackson (ed.), *The Routledge History of Disease* (Abingdon and New York, 2017), pp.1-13.

This chapter, therefore, will interpret disease in its broadest sense, equating it to sickness, to injury, to any complaint for which an individual would seek medical treatment. This includes conditions such as syphilis and colic, alongside more nebulous terms such as 'stomach complaints' and 'spitting of blood'. However, the study of dispensary admissions of these conditions must come with certain caveats. This study focuses on those individuals who sought treatment from a dispensary for their complaint, a group which only ever comprised a small proportion of the sick in any locality. Moreover, changing rates of disease admissions do not simply reflect changing instances of these diseases in society; they also reflect a development in the willingness of individuals to present themselves at a dispensary for treatment.

This chapter will uncover the changing patterns of disease at the Edinburgh, Newcastle, and Kelso dispensaries in the context of changing terminology, changing patterns in use of dispensary services, and relevant local environmental and economic conditions. In doing so, it will provide contrast with the provision available through other local forms of charitable medical relief and explore the reality behind the application of certain disease categories by considering the symptoms of patients, as well as their diagnosed complaints. Overall, it will be argued that dispensaries provided access to medical services for those who suffered from complaints which had previously received little attention from charitable medical institutions. This was particularly the case with those conditions which were viewed as chronic and unlikely to be fatal; individuals suffering from such complaints formed an increasingly significant component of dispensary admissions over the course of the late eighteenth and early nineteenth centuries.

5.1 An Overview of Disease Categories

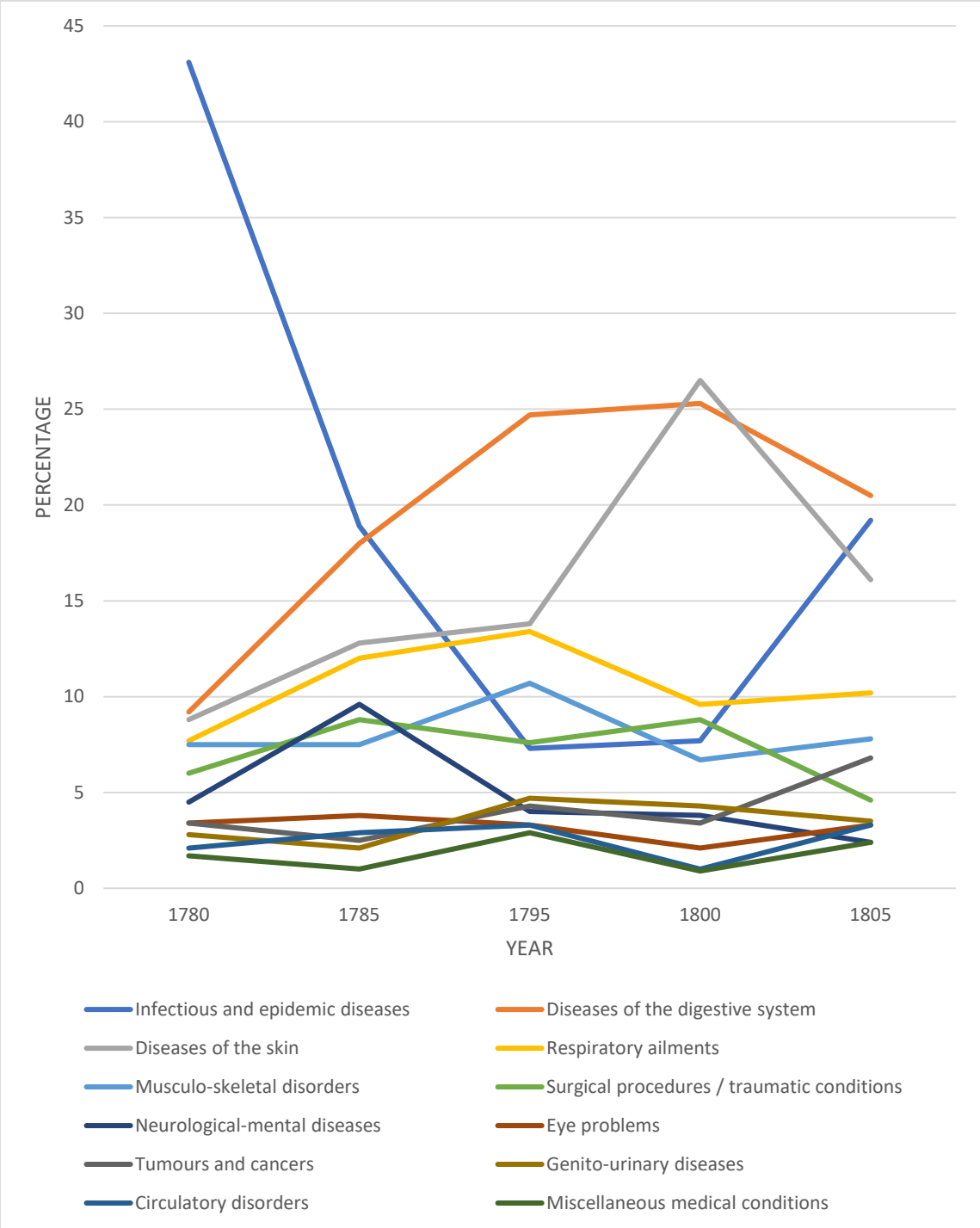
While only anecdotal evidence is available for the Edinburgh dispensary, statistical data is available for both the Kelso and Newcastle dispensaries. Figures 5.1 and 5.2 detail admissions to these dispensaries by individual disease categories. These categories are based upon the system of classification developed by Risse.[617] Although the broad headings contained in these figures, such as 'genito-urinary diseases' and 'circulatory disorders', were devised by Risse himself rather than being based on historical terminology, his decisions

[617] Risse's system of classification is discussed in more detail in the introduction to this thesis.

regarding which diseases he placed in each category were derived from an eighteenth-century understanding of disease causation and the seat of certain illnesses.[618] Risse particularly utilised the writings of William Cullen as a basis for his classification.[619] For example, while modern medical studies identify diabetes as a condition relating to the pancreas and its creation of insulin, this connection was only identified in the late nineteenth century.[620] Prior to this, the sweet taste of the urine of those suffering from diabetes resulted in this disease commonly being characterised as a urinary complaint.[621] Diabetes, therefore, has been placed in the category of genito-urinary diseases. Further information about the breakdown of diseases into these categories is provided in the Appendix.

[618] Risse, 'Hospital History: New Sources and Methods', pp.178-179.
[619] Risse, *Hospital Life in Enlightenment Scotland*, p.121.
[620] Leslie Sue Lieberman, 'Diabetes', in Kenneth F. Kiple (ed.), *The Cambridge World History of Human Disease* (Cambridge, 1994), pp.665-666.
[621] Ibid., p.665.

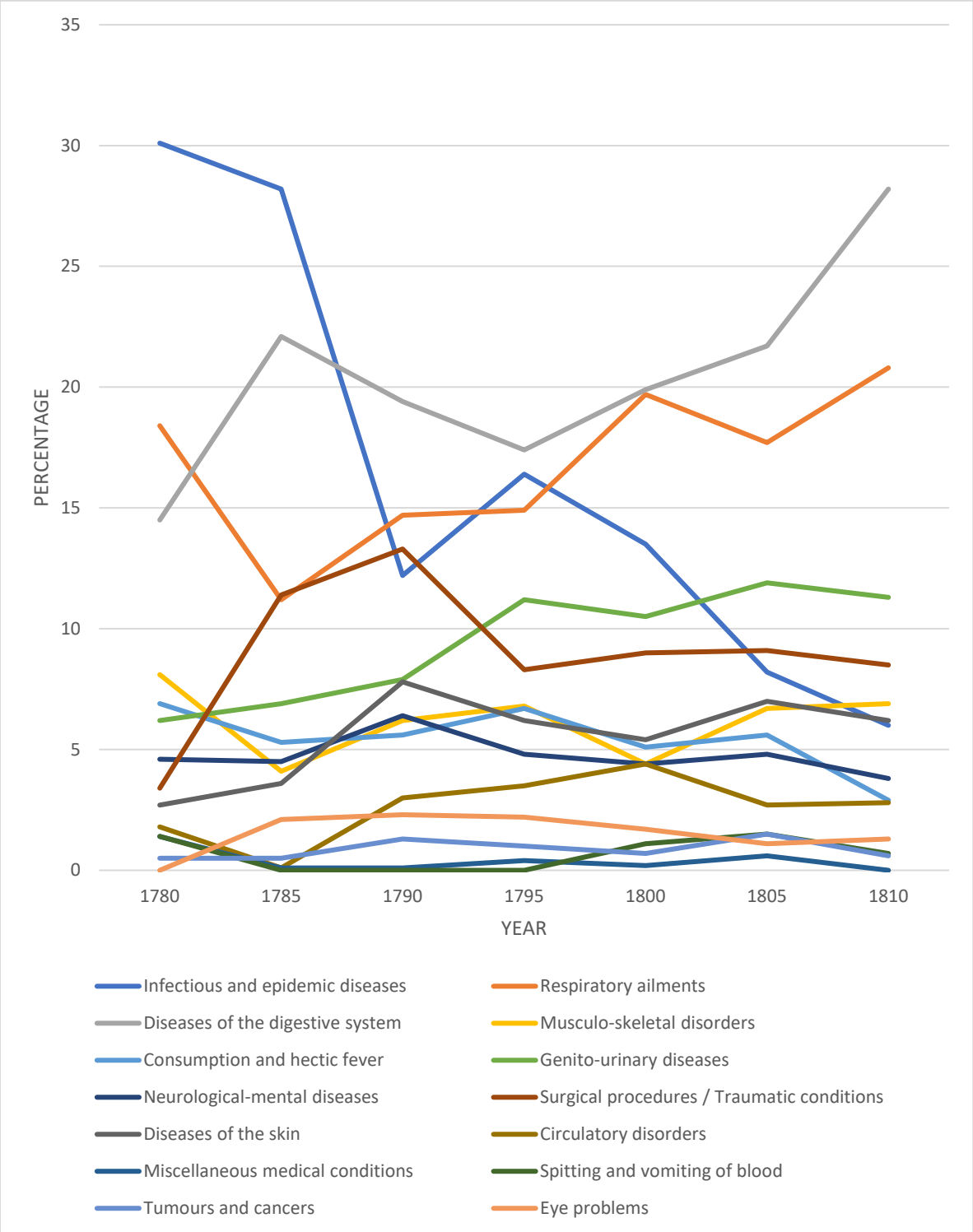
Figure 5.1. Breakdown of diagnostic categories of patients admitted to the Kelso dispensary, as a percentage of total admissions, 1780-1805.[622]



Source: *Kelso Dispensary Patient Registers*, 1780-1805 (HH71/7-8 and HH71/43).

[622] 'Miscellaneous medical conditions' contains entries which do not fit within the diagnostic categories including 'bite of a dog' and 'a broke needle in hip'.

Figure 5.2. Breakdown of diagnostic categories of patients admitted to the Newcastle dispensary, as a percentage of total admissions, 1780-1810.[623]



Source: Anon., *Newcastle Dispensary Annual Reports* (Newcastle, 1780-1810).

[623] These totals do not include those patients who were admitted as 'casualties and slight cases admitted without recommendations' as detail regarding the type of condition they were admitted for was not recorded.

Over 300 individual disease terms were in use at the Kelso and Newcastle dispensaries during the late eighteenth and early nineteenth centuries. It is beyond the scope of this analysis to consider each of these in detail. Instead, groups of diseases have been selected for in-depth study based on the frequency of their occurrence and the insights which they provide into dispensary medical treatments of the sick poor. This chapter, therefore, will consider two categories of complaint which particularly exemplify the distinctive nature of disease incidence and medical provision at the Edinburgh, Kelso, and Newcastle dispensaries. These are genito-urinary diseases and diseases of the digestive system.

5.2 Genito-Urinary Diseases

The historiography of venereal infections has often been separated from the study of other conditions which relate to the genitals, such as urinary and uterine diseases.[624] Venereal diseases have received a great deal of historians' attention, in contrast to the relative paucity of studies of other, often symptomatically similar, diagnoses, such as bladder complaints.[625] The analysis carried out in chapter four of this thesis, however, has demonstrated how diagnosis was based on limited physical and verbal examination and disease terminology was often applied in a varied, obtuse, or even conflicting manner. Under these circumstances it is not clear how easily such distinctions between diseases could be made in practice. This study, therefore, will consider the range of genito-urinary complaints, including urinary, uterine, and venereal diseases, which were treated by dispensaries in the late eighteenth and early nineteenth centuries. As statistical data is not available for the Edinburgh dispensary and the levels of admission of genito-urinary cases

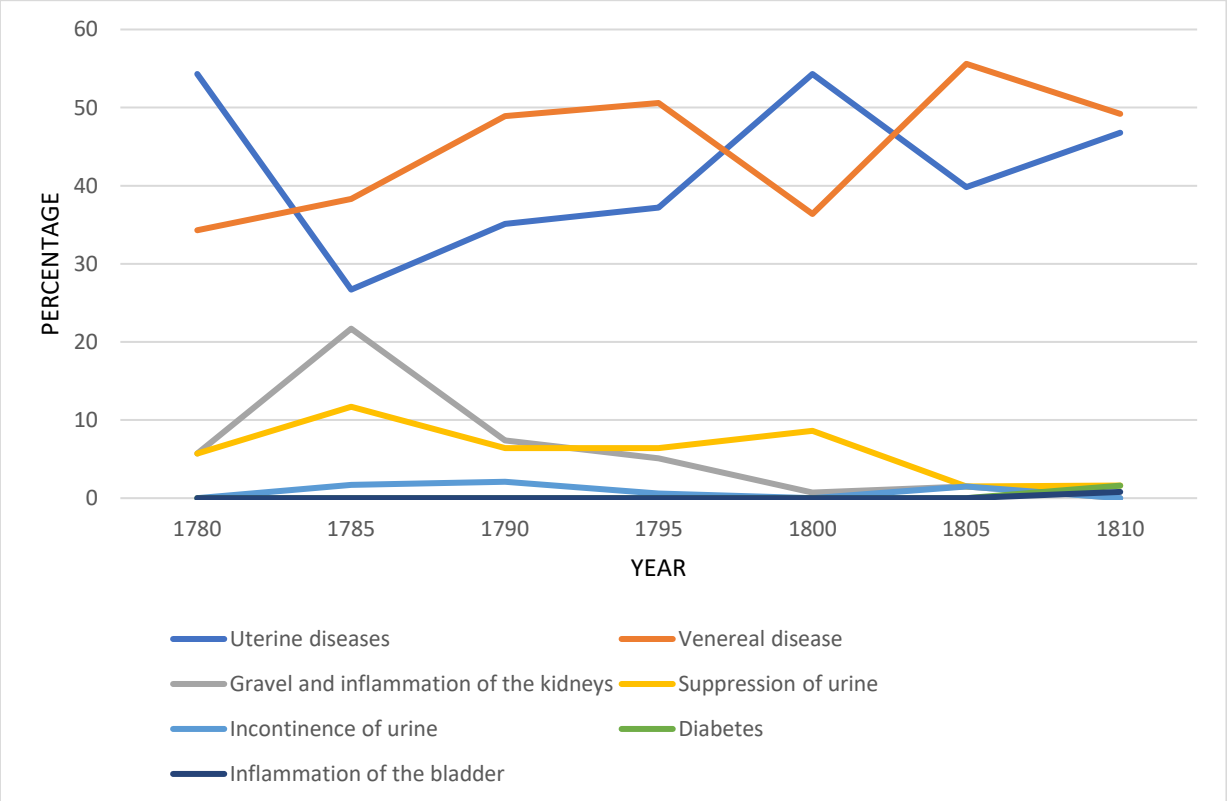
[624] See, for example, Kevin Brown, *The Pox: The Life and Near Death of a Very Social Disease* (Stroud, 2006); Monika Pietrzak-Franger, *Syphilis in Victorian Literature and Culture: Medicine, Knowledge and the Spectacle of Victorian Invisibility* (Cham, 2017).

[625] Although certain texts, including an edited work by Dietrich von Engelhardt, focus specifically on conditions relating to urinary complaints, a great deal of the existing writing on this subject has been carried out by medical practitioners rather than historians. See Dietrich von Engelhardt (ed.), *Diabetes: Its Medical and Cultural History: Outlines, Texts, Bibliography* (Berlin and Heidelberg, 1989); Dirk Schultheiss, Klaus Höfner, Matthias Oelke, Volker Grünewald and Udo Jonas, 'Historical Aspects of the Treatment of Urinary Incontinence', *European Urology*, 38:3 (2000), p.352-361; Julio T. Chong and Vannita Simma-Chiang, 'A Historical Perspective and Evolution of the Treatment of Male Urinary Incontinence', *Neurourology and Urodynamics*, 37:3 (2018), pp.1169-1174.

were particularly low at the Kelso dispensary, the statistical evidence for this analysis is based primarily on the study of the Newcastle dispensary.

The percentage of diagnoses recorded by the Newcastle dispensary which, according to Risse's classification, would be characterised as genito-urinary increased from 6.2 per cent in 1780 to 11.3 per cent in 1810 (Figure 5.2). To further study the significance of this increase we must first consider what types of genito-urinary complaints were admitted during this period. Figure 5.3 demonstrates the breakdown of this classification. By 1810, genito-urinary complaints were overwhelmingly diagnosed in two categories uterine diseases and venereal diseases which comprised, respectively, 46.8 per cent and 49.2 per cent of the total. In the case of other conditions, such as inflammation of the kidneys and incontinence of urine, by 1810 rates of their admission had reduced to zero. Other diagnoses, such as inflammation of the bladder and suppression of urine, each comprised less than two per cent of genito-urinary cases in that year.

Figure 5.3. Breakdown of cases of genito-urinary diseases at the Newcastle dispensary, as a percentage of total genito-urinary diseases, 1780-1810.



Source: Anon., *Newcastle Dispensary Annual Reports* (Newcastle, 1780-1810).

Some of the fluctuations demonstrated in figure 5.3 appear to have been due to changes in systems of disease classification. Over the course of the eighteenth century, urinary complaints were increasingly seen by many practitioners as not themselves distinct conditions, but rather as symptoms of separate diseases. In his book *A General System of Surgery*, the German surgeon Lorenz Heister argued that urinary incontinence could be an indication that the patient suffered from bladder stones or another bladder-related condition.[626] Duncan, when examining cases at the Edinburgh dispensary, identified excessive urination in cases of jaundice and noted lack of urination as a symptom in cases of anasarca.[627] The latter condition, in modern day medical texts itself identified as a symptom of organ failure rather than as a disease in its own right, was characterised by swelling of the skin and constipation as well as impeded urination.[628]

Duncan also, like Heister, identified urinary complaints as a symptom of bladder stones, although he argued that too little, rather than too much, urination was the primary indicator.[629] In the case of one patient, Frances Clerk, whose case is discussed in chapter four, Duncan identified the existence of a stone in her bladder not only by her impeded urination, but by Clerk's report of abdominal pains and by the appearance of sand in her urine.[630] According to Duncan's notes, although this stone could be 'remov[e]d by cutting', Clerk was unwilling to undergo this procedure.[631] Duncan continued: 'Of this mode of cure then [it is] unnecess[ary] to say [any] more', before resorting to a range of medicaments.[632] Fear of surgical cutting to remove stones, a procedure also known as lithotomy, was not uncommon among patients during this period.[633] Indeed, Daniel Defoe, writing in 1725, described the experience of undergoing this procedure as being 'torn and mangled by the merciless Surgeons, cut open alive, and bound Hand and Foot… the very Apparatus is enough to chill the Blood'.[634] Regardless of such concerns, however, over the course of the

[626] Lorenz Heister, *A General System of Surgery in Three Parts, Volume Two* (London, 1743), p.86.
[627] Andrew Reid, *Practical Observations in Medicine by Andrew Duncan*, 1780-1781 (DEP/DUA/1/25), pp.100-107; Rachael Drummond, *Practical Observations in Medicine by Andrew Duncan*, 1784 (DEP/DUA/1/37), pp.10-22.
[628] Elizabeth A. Martin (ed.), *Concise Medical Dictionary* (Oxford, 1998), p.29.
[629] John Stuart, *Practical Observations in Medicine by Andrew Duncan*, 1785 (DEP/DUA/1/37), pp.318-327.
[630] Frances Clerk, *Practical Observations in Medicine by Andrew Duncan*, 1777-1778 (DEP/DUA/1/16), pp.115-131.
[631] Ibid., p.125.
[632] Ibid.
[633] Peter Stanley, *For Fear of Pain: British Surgery, 1790-1850* (Amsterdam and New York, 2003), pp.84-87.
[634] Paula Backscheider, *Daniel Defoe: His Life* (Baltimore and London, 1989), p.493.

eighteenth century surgical intervention increasingly became the preferred model for treatment of this condition rather than the prescription of medicines.[635] Previously considered to be primarily the preserve of folk healers, reputable surgeons who were known for their skill in the process of lithotomy began to rise to prominence and hospitals employed such specialists in increasing numbers by the end of the century.[636] Treatment for the stone, therefore, increasingly fell within the remit of infirmary surgeons rather than dispensaries. That any patients at all sought admission to dispensaries for treatment of this condition in the later eighteenth century may have been the result of their fear of surgical intervention, as exemplified in the case of Clerk.

The neat ordering of diseases in the Newcastle dispensary annual reports into distinct categories such as uterine and venereal complaints belies the underlying complexity of arriving at these diagnoses. Duncan emphasised in the case of Agnes Reid, who was admitted into the care of the Edinburgh dispensary in the summer of 1780, that forming a 'distinct[ion] [between leucorrhoea and gonorrhoea was] often extrem[ely] diffic[ult]', the primary symptom in both conditions being a whitish vaginal discharge.[637] Leucorrhoea was far from the only condition which could prove difficult to distinguish from a venereal infection. Butler has questioned whether a proportion of those who were diagnosed at the Newcastle dispensary with 'scorbutic eruptions', a condition which comprised 5.6 per cent of all admissions in 1810, may have been suffering from venereal complaints.[638] Similarly, in a study of eighteenth-century cultural interpretations of the body, Kathryn Woods has highlighted how smallpox and syphilis could be conflated because of similarities in the way they manifested externally.[639] Indeed, the range of conditions which could be confused with venereal complaints in the eighteenth and early nineteenth centuries was extensive,

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[635] Medical treatment continued to be utilised in some instances of the stone, although often primarily when patients showed an unwillingness to undergo surgical intervention. William Cullen, for example, wrote in 1778 in relation to a patient, that 'I cannot doubt of his having a Stone in his bladder… I suppose he will not enter upon [surgery] till he has tried every means of relief by medicine'. See Alexander Dougal, *Correspondence of William Cullen*, 29 May 1778 (DEP/CUL/1/1/10/103). For a more detailed discussion of medical treatments for the stone, see Andreas-Holger Maehle*, Drugs on Trial: Experimental Pharmacology and Therapeutic Innovation in the Eighteenth Century* (Amsterdam and Atlanta, 1999), pp.55-107.

[636] D. De Moulin, 'Cutting for the Stone in the Early Middle Ages'*, Bulletin of the History of Medicine*, 45:1 (1971), p.76; R. Ted Steinbock, 'Urolithiasis (Renal and Urinary Bladder Stone Disease)', in Kenneth F. Kiple (ed.), *The Cambridge World History of Human Disease* (Cambridge, 1994), pp.1090-1091.

[637] *Practical Observations in Medicine by Andrew Duncan*, 1780 (DEP/DUA/1/26), p.73.

[638] Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne', p.172; Anon., *Newcastle Dispensary Annual Report* (1810), n.p.

[639] Woods, 'Dismembering Appearances', p.98.

including scrofula, rheumatism, tuberculosis, ulcers, gout, and lameness.[640] While it is not desirable either to engage in retrospective diagnosis to determine which of these terms were, in practice, applied to instances of venereal infections, these findings offer a note of caution in relying on published dispensary figures to determine genuine fluctuations in levels of venereal disease.

Even defining what is meant by the broad category of venereal disease, as it was applied in the eighteenth century, is complex. There was considerable debate amongst medical practitioners of the period as to whether syphilis and gonorrhoea were separate diseases or simply different stages, or manifestations, of the same condition. While William Cullen and the surgeon John Hunter aligned with the unicist theory, others, including the Edinburgh surgeon Benjamin Bell and Andrew Duncan, argued that gonorrhoea and syphilis were two distinct diseases.[641] Furthermore, Kevin Siena has emphasised that where the term 'venereal' was applied to patients during this period, it was often used to describe a range of genito-urinary and skin complaints, not all of which were the result of sexual activity.[642] He carried out a detailed study of one such example, 'the itch', a skin condition the transmission of which was believed by many to have connections to sexual licentiousness.[643]

Siena cites Duncan as one of the medical authorities who propounded this theory, quoting the physician's printed case notes in which Duncan described how a single woman could have contracted multiple diseases and, therefore, could have transmitted syphilis to one man, to another man gonorrhoea and, 'Had she also been subject to the itch, a third might have caught that infection'.[644] In the more detailed handwritten notes of this case, however, it is clear that Duncan was not describing the itch as a venereal infection, but rather he was arguing that it is illogical to view syphilis and gonorrhoea as the same disease

[640] Mary Key, *Practical Observations in Medicine by Andrew Duncan*, 1782-1783 (DEP/DUA/1/31), pp.5-16; John Auchinlech, *Practical Observations in Medicine by Andrew Duncan*, 1778-1779 (DEP/DUA/1/19), pp.79-84; Sheldon Watts, *Epidemics and History: Disease, Power and Imperialism* (New Haven and London, 1997), p.122; Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne', p172.
[641] Claude Quétel, *History of Syphilis* (Cambridge, 1990), pp.82-83; J. D. Oriel, *The Scars of Venus: A History of Venereology* (London, 1994), pp.26-34; Richard B. Rothenberg, 'Gonorrhea', in Kenneth F. Kiple (ed.), *The Cambridge World History of Human Disease* (Cambridge, 1994), p.759-760.
[642] Kevin Siena, 'Pollution, Promiscuity, and the Pox: English Venereology and the Early Modern Medical Discourse on Social and Sexual Danger', *Journal of the History of Sexuality*, 8:4 (1998), p.556.
[643] Kevin Siena, 'The Moral Biology of 'the Itch' in Eighteenth-Century Britain', in Jonathan Reinarz and Kevin Siena (eds), *A Medical History of Skin: Scratching the Surface* (London and Brookfield, 2013), pp.71-83.
[644] Ibid., p.74.

based on similarities between certain of their symptoms. The fact that, on some occasions, both diseases had been transmitted by the same individual, Duncan warned, should not be used as evidence, because this approach could also be used 'to prove [the] sameness of [the] matt[e]r of Small Pox & [the] itch'.[645] Elsewhere, Duncan characterised the itch as a cutaneous disease, rather than a venereal one, identifying its primary cause as 'want of cleanin[e]ss'.[646] Although Duncan's elaborated point does not entirely refute Siena's argument, it does demonstrate that, while notions of sexual impropriety could be attached to the contraction of skin conditions in much the same way as they were with diseases such as syphilis, this was not uniformly the case.

Discussions of sexual licentiousness and concepts of societal shame have often been at the centre of historiographical studies of venereal complaints.[647] Indeed, Jonathan Andrews has argued that the moral context of venereal disease is frequently overemphasised, an approach which has often been combined with an overwhelming focus on elite sufferers.[648] Studies which primarily consider the wealthier patients of a physician's private practice often discuss the euphemistic language used to describe venereal complaints and the emphasis which was placed on the importance of anonymity to prospective clients.[649] What is less clear, however, is the role which notions of shame and the fear of social condemnation played in the diagnosis and treatment of poor patients. Historians, including Siena and Butler, have argued that individuals who had contracted a venereal complaint would often lie to disguise their condition when seeking admission to charitable institutions.[650] The argument which underpins this analysis is that, as a result,

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[645] Dan Robertson, *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/13), pp.44-48.
[646] Kath Reid, *Practical Observations in Medicine by Andrew Duncan*, 1780-1781 (DEP/DUA/1/24), p.185; Ann Neal, *Practical Observations in Medicine by Andrew Duncan*, 1779-1780 (DEP/DUA/1/22), p.92.
[647] See, for example, Theodor Rosebury, *Microbes and Morals: The Strange Story of Venereal Disease* (London, 1972); Winifred Schleiner, 'Moral Attitudes toward Syphilis and Its Prevention in the Renaissance', *Bulletin of the History of Medicine,* 68:3 (1994), pp. 389-410.
[648] Andrews, 'History of Medicine: Health, Medicine and Disease in the Eighteenth Century', p.507. Bertrand Taithe has made similar arguments in a review article. See Bertrand Taithe, 'Morality is not a Curable Disease: Probing the History of Venereal Diseases, Morality and Prostitution', *Social History of Medicine*, 14:2 (2001), pp.337-350.
[649] Kevin Siena, 'The 'Foul Disease' and Privacy: The Effects of Venereal Disease and Patient Demand on the Medical Marketplace in Early Modern London', *Bulletin of the History of Medicine*, 75:2 (2001), pp. 199-224; Christi Keating Sumich, 'Soul Sick Stomachs, Distempered Bodies, and Divine Physicians: Morality and the Growth of the English Medical Profession' (Ph.D. diss., Tulane University, 2008), pp.172-176.
[650] Kevin Siena, 'The Clean and the Foul: Paupers and the Pox in London Hospitals, c.1550-c.1700', in Kevin Siena (ed.), *Sins of the Flesh: Responding to Sexual Disease in Early Modern Europe* (Toronto, 2005), pp.270-271; Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne', p.172.

statistical studies of such institutions will inevitably underestimate rates of venereal diseases. The evidence demonstrated in figure 5.3, however, lays open to question the extent to which this assumption is accurate. When levels of admission for venereal conditions often totalled around 50 per cent of genito-urinary cases is it realistic to assume that this comprised only a small percentage of the actual number of admissions of these diseases?

Duncan certainly believed that his dispensary patients were unlikely to lie about having contracted such a condition. In the case of Hamilton Bowie, aged 27, who was admitted into the Edinburgh dispensary in May 1783 with a condition which appeared to be either leucorrhoea or gonorrhoea, Duncan asserted that he did not believe it was a venereal complaint because Bowie 'could have little reason for conceal[ing] it' as her 'desire of [a] cure [one] might suppose would be suff[icient] motive for telling us the truth'.[651] According to Duncan, therefore, because patients understood that an accurate diagnosis was essential for providing effective treatment, they would have disclosed any exposure they may have had to venereal disease. This may appear to be an overly optimistic statement by Duncan, however there were some grounds for his optimism.

The Edinburgh dispensary, like most other dispensaries during the eighteenth century, avoided much of the moralistic censoring which was often pronounced in relation to other charitable bodies such as workhouses and infirmaries. When John Mason Good, a fellow of the Medical Society of London, carried out a survey of English workhouses, he wrote, on the subject of venereal infection, that the poor 'are liable to… a thousand temptations, which every superior rank of life is free from; and they feel not, from want of education, the same happy exertion of delicacy, honor, and moral sentiment, which every where else is to be met with'.[652] A similar attitude can often be found in the publicity material of infirmaries, where the importance of prayer, bible readings, and moral rectitude was frequently emphasised.[653] Even more stridently, the regulations of St. Cuthbert's Charity Workhouse detailed that a failure to regularly attend divine worship would result in an adult being 'deprived of their next meat', with repeat offenders 'locked up in a room,

[651] Hamilton Bowie, *Practical Observations in Medicine by Andrew Duncan*, 1783 (DEP/DUA/1/32), p.66.
[652] John Mason Good, *A Dissertation on the Diseases of Prisons and Poor Houses* (London, 1795), p.27.
[653] Risse, *Mending Bodies, Saving Souls*, p.234.

without getting any victuals for a whole day'.[654] Children under 10 who did not comply with this regulation would be 'corrected by whipping'.[655] In such institutions, therefore, charity was often interwoven with elements of moral reform and condemnation.

Moreover, cases of deception were inevitably more pronounced when institutions restricted access to individuals suffering from venereal complaints, an approach commonly adopted by English infirmaries. While the Edinburgh infirmary, by contrast, openly admitted venereal cases, those 'female patients… being sufferers, not by any fault of their own' were separated from those 'whose conduct and manners are less correct'.[656] In the case of the Newcastle infirmary, as mentioned in chapter one, its printed regulations in 1751 explicitly excluded venereal cases from admission.[657] The infirmary's 1801 statutes and rules contained a significant revision, however, in which venereal cases were identified as a group where, in the case of some patients, 'false names have been frequently affixed to their distemper' by physicians in order to grant their admission.[658] To ameliorate this issue, the rules were then revised to allow for the admission of certain cases, with an emphasis placed upon 'Married women, of good character and strict morals' who were 'often ignorant of their cases'.[659]

The openness with which these rules had previously been flouted is made clear from an entry made in the Newcastle infirmary's visitors' book in August 1792 by a subscriber who, on an inspection of the wards, was informed that 'many of the Patients have the Foul Disease… I should recommend no such Persons to be admitted because there is a Rule against it'.[660] An even more stark example of the extent to which these regulations were ignored is found in a printed case study dating from 1797 which describes in detail the treatment at the Newcastle infirmary of a syphilitic individual whose 'foul ulcer' had

[654] *St. Cuthbert's Parish Church Minute and Account Book of Poor Funds*, 27 May 1762 (CS96/295).
[655] Ibid.
[656] Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1778), p.11.
[657] Anon., *Statutes, Rules, and Orders for the Government of the Infirmary for the Sick and Lame Poor of the Counties of Durham, Newcastle Upon Tyne and Northumberland* (Newcastle, 1751), pp.18-19.
[658] Anon., *A Code of Statutes and Rules for the Government of the Infirmary for the Counties of Newcastle Upon Tyne, Durham, and Northumberland*, p.26.
[659] Ibid., pp.25-26.
[660] *Newcastle Infirmary House Visitors' Book*, 31 August 1792 (TWA, HO/RVI/148/1).

destroyed 'at least one-half of the glans penis'.[661] The patient, William Dawson, aged 29, spent almost three months in the infirmary before being discharged.[662]

The deception here appears to have been carried out by the diagnosing physician rather than by the patient himself. Concern regarding social morality, therefore, where it manifests in relation to charitable patients, appears to lie primarily with subscribers and managers of the institution rather than the physicians. In the case of the Edinburgh dispensary, where there was no active board of subscribers overseeing its regulations and administration, it was able to avoid placing restrictions on access to medical treatment for venereal cases. Indeed, often when patients presented themselves for admission to that institution, such as in the case of Daniel Robertson, who sought treatment in March 1777, they were immediately forthcoming about their condition.[663] For Robertson 'ascribes his disease to venereal infection; but he is not certain of the particular time at which he received it'.[664]

The outpatient model of treatment adopted by dispensaries further protected individuals from any potential stigma attached to such a diagnosis. When infirmaries, such as that at Edinburgh, formally admitted venereal cases they were commonly housed in separate 'foul' or 'salivating' wards.[665] These individuals were, therefore, clearly delineated from other patients and their diagnosis made more visible to the wider community. At a dispensary, by contrast, the patient arrived to be treated, collected their medicines and left, with no outward signs beyond the physical manifestations of their illness to indicate their condition. Indeed, the sensitivity which dispensary physicians demonstrated towards the importance of patient privacy in such cases is evidenced by the fact that, when Duncan published his case notes, the name of the individual who had been diagnosed with venereal disease was anonymised. Daniel Robertson became 'D- R-', a model which was not uniformly adopted by Duncan in relation to other diagnoses.[666] By contrast, this approach

[661] Thomas Beddoes, *A Collection of Testimonies Respecting the Treatment of the Venereal Disease by Nitrous Acid* (London, 1799), pp.216-220.
[662] Ibid.
[663] Duncan, *Medical Cases, Selected from the Records of the Public Dispensary at Edinburgh*, p.205-231.
[664] Ibid., p.205.
[665] The title applied at the Edinburgh infirmary was 'salivating ward'. See Anon., *The History and Statutes of the Royal Infirmary of Edinburgh* (Edinburgh, 1778), p.11. The description of 'foul wards' was also commonly applied. For a more detailed study of such cases, see Kevin P. Siena, *Venereal Disease, Hospitals and the Urban Poor: London's 'Foul Wards,' 1600-1800* (Rochester and Woodbridge, 2004).
[666] Duncan, *Medical Cases, Selected from the Records of the Public Dispensary at Edinburgh*, p.205.

was not taken in the published Newcastle infirmary venereal case study previously mentioned, where the patient was clearly identified by name.[667]

However, while there was the opportunity for a level of anonymity for dispensary patients in large cities such as Edinburgh and Newcastle, it is more questionable whether this would have been possible in a town such as Kelso. While the Kelso dispensary's regulations contained no embargo against the admission of such cases, the possibility that unwritten rules were applied by their staff or, indeed, that there was an unwillingness of sufferers to approach the institution for treatment cannot be ignored. In the data surveyed for this thesis, covering the period from 1780 to 1810, there were only three recorded admissions of venereal patients at the Kelso dispensary.[668] One patient whose name, unusually, was not recorded, was diagnosed with *lues venerea* in 1800 and, in 1795, 24 year-old Bridget Reynolds and her six month old child were both admitted with a recorded diagnosis of syphilis.[669] Historiographical studies, including the detailed research of Simon Szreter, have found that rates of venereal diseases were considerably higher in cities than in rural districts during this period.[670] The extremely small number of admissions of such conditions in Kelso, however, also suggests additional factors, such as individuals from the local community being unwilling to submit themselves for treatment at a public institution.

The role of the Kelso dispensary in the treatment of venereal disease was, therefore, significantly less pronounced than was the case with its counterparts in Edinburgh and Newcastle. Indeed, its admission of all forms of genito-urinary diseases was extremely low in contrast to other such institutions. Figure 5.1 demonstrates how rates of these conditions at their highest totalled only 4.7 per cent of all admissions. This was due, in part, to the high rates of admission of other conditions, such as digestive complaints. However, it may also imply a perceived societal connection, as Siena has asserted, between notions of shame and all conditions relating to the reproductive organs.

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[667] Beddoes, *A Collection of Testimonies Respecting the Treatment of the Venereal Disease by Nitrous Acid*, pp.216-220.

[668] These findings are based on analysis of all admissions for the years 1780, 1785, 1795, 1800, and 1805. *Kelso Dispensary Patient Registers*, 1780-1805 (HH71/7-8 and HH71/43).

[669] *Kelso Dispensary Patient Register,* 10 July 1795 and 27 July 1800 (HH71/43).

[670] Simon Szreter, 'Treatment Rates for the Pox in Early Modern England: A Comparative Estimate of the Prevalence of Syphilis in the City of Chester and its Rural Vicinity in the 1770s', *Continuity and Change*, 32:2 (2017), pp.183-210.

5.3 Diseases of the Digestive System

Complaints related to the stomach and digestion were amongst the most common conditions admitted to dispensary care; by the early nineteenth century they comprised up to 28.2 per cent of all admissions to the Kelso and Newcastle dispensaries (Figures 5.1 and 5.2). In spite of the frequency of such conditions, until recently this area of historical medical diagnosis and treatment has been notably understudied. The historian David Boyd Haycock has attributed this, in part, to the lack of 'exotic shock factor' of conditions such as dysentery.[671] Ana Carden-Coyne and Christopher Forth have argued, similarly, that the commonplace and often relatively unchanging nature of diet and ailments of the stomach has made this an unattractive field of study.[672] The stomach in its more conceptual form has proved more popular, and works such as that of David Hillman and Carla Mazzio have studied the cultural meanings of the stomach in literature and art.[673]

When considering the stomach in its more prosaic corporeal form, its afflictions were certainly not the most immediately critical. Over the period of study of this thesis the Kelso dispensary witnessed low rates of fatalities for stomach-related conditions, with only eight individuals recorded as having died of such complaints.[674] This is not to diminish their impact, however. Even where such ailments did not kill, they could still significantly affect an individual's life by preventing them from being able to earn a living or care for their children. They could, as in the case of 19-year-old John Stark, admitted into the care of the Edinburgh dispensary in January 1784, make a patient 'weak & emaciated' and cause significant discomfort.[675] In Stark's case, his diarrhoea caused 'a pain at the bottom of the fundament which is so violent, that he cannot sit down or walk without suffering the most excruciating torment'.[676]

Figures 5.4 and 5.5 demonstrate the range of diseases of the digestive system which were treated at the Kelso and Newcastle dispensaries. Many of these digestive complaints

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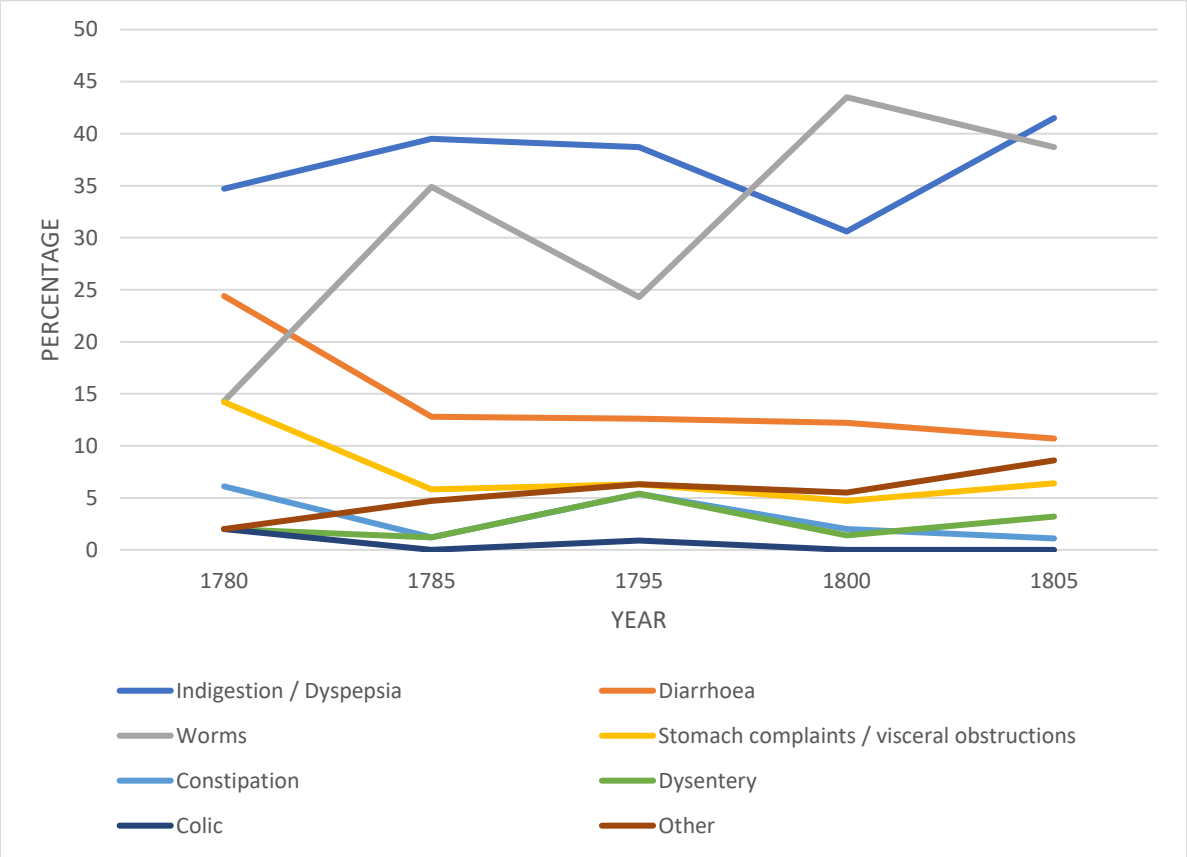
[671] David Boyd Haycock, 'Exterminated by the Bloody Flux', *Journal for Maritime Research*, 4:1 (2002), p.16.
[672] Ana Carden-Coyne and Christopher E. Forth, 'The Belly and Beyond: Body, Self, and Culture in Ancient and Modern Times', in Christopher E. Forth and Ana Carden-Coyne (eds), *Cultures of the Abdomen: Diet, Digestion, and Fat in the Modern World* (Basingstoke, 2005), p.2.
[673] David Hillman and Carla Mazzio (eds), *The Body in Parts: Fantasies of Corporeality in Early Modern Europe* (London and New York, 1997).
[674] These findings are based on analysis of all admissions for the years 1780, 1785, 1795, 1800 and 1805. *Kelso Dispensary Patient Registers*, 1780-1805 (HH71/7-8 and HH71/43).
[675] *Practical Observations in Medicine by Andrew Duncan*, 1784 (DEP/DUA/1/34), p.109.
[676] Ibid.

would have been viewed as chronic, rather than acute, some of which the sufferers would have laboured under for extremely protracted periods of time. In one case, admitted into the Edinburgh dispensary in the winter of 1785, the patient, James Goodall, had been subject to diarrhoea for over thirty years.[677] Indeed, it was argued by the dispensary physician that after such a long time it was 'somewhat doubtful whether [it] would be safe or prop[er]' to attempt to cure Goodall's condition, for 'after [a] habit so long accust[omed] to such a disch[arge]' negative consequences could result from its sudden cessation.[678]

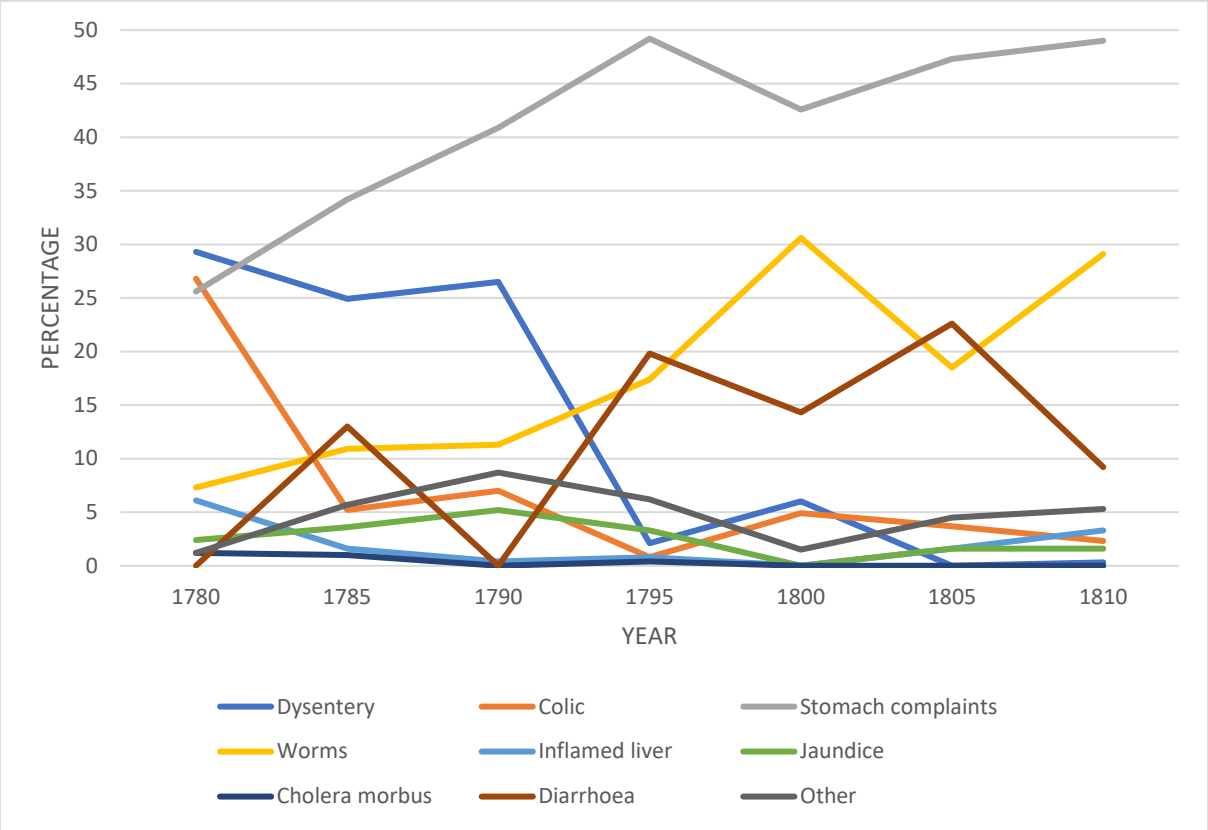
Figure 5.4. Breakdown of cases of diseases of the digestive system at the Kelso dispensary, as a percentage of total diseases of the digestive system, 1780-1805.[679]



Source: *Kelso Dispensary Patient Registers*, 1780-1805 (HH71/7-8 and HH71/43).

[677] *Practical Observations in Medicine by Andrew Duncan*, 1785 (DEP/DUA/1/38), pp.23-24.
[678] Ibid.
[679] The category of 'other' comprises: 'diseased liver', 'vomiting', 'jaundice', 'bowel complaints / flatulence', 'difficulty swallowing', and 'cholera'.

Figure 5.5. Breakdown of cases of diseases of the digestive system at the Newcastle dispensary, as a percentage of total diseases of the digestive system, 1780-1810.[680]



Source: Anon., *Newcastle Dispensary Annual Reports* (Newcastle, 1780-1810).

Caution must be taken when interpreting the disease terms used in figures 5.4 and 5.5. The designation of cholera, for example, a disease of which there were few cases diagnosed at either the Kelso or Newcastle dispensaries during the period under study, should not be conflated with modern medical understanding of this term. Cholera, in eighteenth-century nomenclature, was commonly shorthand for cholera morbus, a gastrointestinal complaint.[681] Its aetiology was not the same as that of the condition known as Asiatic cholera, a disease which was widespread across nineteenth-century Europe but which was only introduced into Britain in the 1830s.[682] By contrast, in this earlier period,

[680] In 1780 the categories of dysentery and diarrhoea were combined under a single heading, so it is not possible to distinguish the breakdown of the total of 29.3 per cent between these two categories. In 1790 the categories of diarrhoea and 'obstinate fluxes' (an alternative name for dysentery) were combined under a single heading. The category of 'other' comprises: 'abdominal obstructions', 'spitting of blood', 'mortification of the bowels', 'schirrhus of the gullet', and 'constipation'.
[681] Reinhard S. Speck, 'Cholera', in Kenneth F. Kiple (ed.), *The Cambridge World History of Human Disease* (Cambridge, 1993), pp.642-647.
[682] Ibid.

according to Norman Howard-Jones, the term cholera was a 'blunderbuss epithet', applied in a wide range of instances where individuals experienced diarrhoea or cramps.[683]

The use of colic as a disease classification has a similar diagnostic history. Now a term primarily associated with infants, in eighteenth-century dispensary records it was more often a complaint of adults.[684] The identified causes of this condition varied between medical practitioners, though diet and extremes of temperature were often considered to be key factors.[685] In one case the military physician Sir John Pringle, who wrote extensively on the subject of epidemic and digestive complaints, analysed the causes of the 'colic pain' of his wife's maid.[686] These had been brought about, according to Pringle, by the maid becoming overheated during her work and then drinking a glass of beer.[687] According to Duncan colic could also be induced by eating honey, even in extremely small quantities.[688] With a disease which appears to have been particularly difficult to diagnose accurately, analysing the statistical evidence relating to its frequency is complex.

Rates of colic decreased at both the Kelso and Newcastle dispensaries over the course of the late eighteenth and early nineteenth centuries, most significantly at Newcastle, where it declined from 26.8 per cent of all diseases of the digestive system in 1780 to 2.3 per cent in 1810 (Figure 5.5). The cause of this reduction, however, is most likely due to changes in terminology rather than changes in the instance of symptoms of this condition, with cases probably having been subsumed into other classifications, such as stomach complaints. The overuse of colic as a disease category during the eighteenth century was emphasised by Duncan, who bemoaned that among some 'nosol[ogical] writers all pains of [the] intest[ines] [which are] not from any fix[e]d cause [are] refer[red] only to [the] general head of colica'.[689]

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[683] Norman Howard-Jones, 'Choleranomalies: The Unhistory of Medicine as Exemplified by Cholera', *Perspectives in Biology and Medicine*, 15:3 (1972), pp.427-428.
[684] All recorded cases of colic at both the Edinburgh and Kelso dispensaries during the period under study related to adults rather than children. See *Practical Observations in Medicine by Andrew Duncan*, 1776-1790 (DEP/DUA/1/11-47); *Kelso Dispensary Patient Registers*, 1780-1805 (HH71/7-8 and HH71/43).
[685] *Medical Annotations by Sir John Pringle*, *Volume Three*, c.1770 (RCPE, DEP/PRJ/1/3), p.106; John Clark, *Observations on the Diseases Which Prevail in Long Voyages to Hot Countries, Particularly on Those in the East Indies and on the Same Diseases as they Appear in Great Britain, Volume Two* (London, 1792), pp.396-397.
[686] *Medical Annotations by Sir John Pringle*, *Volume Five*, c.1765 (DEP/PRJ/1/5), p.15.
[687] Ibid.
[688] According to Duncan, the honey included in certain medicinal remedies could even induce colic in patients. See William Bell, *Practical Observations in Medicine by Andrew Duncan*, 1778 (DEP/DUA/1/17), p.89
[689] Alexander Orrock, *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/13), p.174.

By contrast, intestinal worms should, in theory, have been one of the simplest of the digestive complaints to diagnose. Unlike diseases such as cholera and colic there was one very clear and distinctive symptom, namely the expelling of worms or worm fragments from the anus. Unfortunately, diagnosis was not always so simple. Where physical examination of the patient was limited, particularly in diseases which affected areas such as the rectum, the focus instead was on the study of the worms themselves. Physicians frequently emphasised the sheer scale of the creatures, one study describing them as sometimes measuring 'seven or eight Foot long, sometimes nineteen, twenty three, thirty; forty five Foot'.[690] Worms, then, could take on horrifying forms. Dramatic descriptions such as this, however, belie the often commonplace nature of this complaint. At the Edinburgh dispensary the primary indicator of worm infestation was the patient's propensity to pick their nose.[691] Moreover, worm infestation was amongst the conditions most frequently diagnosed at the Edinburgh dispensary in the late eighteenth century. However, as with gynaecological complaints it was often an underlying condition which was treated at the dispensary only when the patient was admitted for a more serious complaint.[692] In some instances patients at the Edinburgh dispensary had been subject to worms for as long as seven years before undergoing dispensary treatment.[693]

Domestic treatments for removing or preventing worms, however, were widely available and, according to William Buchan's *Domestic Medicine,* included 'a glass of red wine' as well as a wide range of laxatives.[694] Folk remedies were often also adopted and Duncan detailed how one of his dispensary patients had taken 'a considerable quantity of garlick' on the 'advice of some of his neighbours' as a treatment for worms.[695] Other

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[690] M. M., *A Short Historical Account of the Several Kinds of Worms Breeding in Human Bodies,* p.31.
[691] Robert Lamb, *Practical Observations in Medicine by Andrew Duncan*, 1785 (DEP/DUA/1/38), p.129; Jean Armourer, *Practical Observations in Medicine by Andrew Duncan*, 1782-1783 (DEP/DUA/1/30), p.231. Duncan, in spite of his frequent assertions that this was a key symptom of intestinal worms, acknowledged he had not identified the cause of this symptom. See Mary McFarlane, *Practical Observations in Medicine by Andrew Duncan*, 1784 (DEP/DUA/1/35), p.15. Itching of the nose was noted as a symptom by other contemporary authors. See, for example, Michael Underwood, *A Treatise on the Diseases of Children, With Directions for the Management of Infants From the Birth; Especially Such as are Brought up by Hand* (London, 1784), p.147.
[692] Isabel Crookshanks, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/12), pp.90-91; Jean Armourer, *Practical Observations in Medicine by Andrew Duncan*, 1782-1783 (DEP/DUA/1/30), p.231. Gynaecological complaints are discussed in more detail in chapter four.
[693] George Don, *Practical Observations in Medicine by Andrew Duncan*, 1787 (DEP/DUA/1/41), p.244.
[694] William Buchan, *Domestic Medicine; or, the Family Physician: Being an Attempt to Render the Medical Art More Generally Useful, by Shewing People What is in Their Own Power Both with Respect to the Prevention and Cure of Diseases* (Philadelphia, 1772), pp.259-261.
[695] William Robertson, *Practical Observations in Medicine by Andrew Duncan*, 1784 (DEP/DUA/1/36), p.38.

treatments were rather more unsavoury; in 1776, the Swedish physician Nils Rosén von Rosenstein recommended tempting the worms out with a piece of pork attached to string, which was inserted into the anus, as well as enemas, the ingredients of which included rats' dung.[696] Enemas were indeed a frequent treatment for intestinal worms and, as well as dung, could contain tobacco smoke and the 'great bastard Black Hellebore', the extract of a flowering plant.[697] Historians, including Lianne McTavish, have connected the approaches taken to combat parasitic worms with humoral theory, whereby treatments such as enemas were applied with the aim of removing excessive humors from within a patient's body.[698] While such an approach was applied for a wide range of medical conditions, in the case of parasitic worms the rationale for such a treatment was often far more prosaic. Duncan's preferred enema formula for his dispensary patients consisted primarily of lime water.[699] The professed aim of this treatment was to poison the worms, thereby forcing them to release their grip on the intestinal wall before laxatives were then employed to flush the worms out of the patient's body.[700]

This view of intestinal worms as commonly being relatively benign, a minor ailment which could be treated with medicaments such as wine, garlic, and pork, was reserved primarily for adults. Greater caution was employed, however, when children became infected. This concern emanated as much from lay individuals as medical practitioners. The historian Diana Gallagher, in a study of parasites in eighteenth-century America, has identified the emphasis placed on safeguarding children from this complaint in works such as *The Compleat Housewife*.[701] Public concern about the impact of worms on children's health is also demonstrated by the admission rates for this condition at the Kelso

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[696] John Rendle-Short, 'Worms in History with Special Reference to Children', *Proceedings of the Royal Society of Medicine*, 50:12 (1957), p.1015.
[697] Ibid.; *Medical Annotations by Sir John Pringle*, *Volume Six*, c.1767 (DEP/PRJ/1/6), p.106. The source of this plant's colloquial name is unknown. Also known as bear's foot, it was a common lay treatment for worms in the eighteenth century. Charles Bisset, *An Essay on the Medical Constitution of Great Britain. To Which are Added Observations on the Weather, and the Diseases Which Appeared in the Period Included Betwixt the First of January 1758, and the Summer Solstice in 1760* (London, 1762), pp.333-339.
[698] Lianne McTavish, 'Intestinal Chaos: Tapeworms, Dead Flesh, and Reproduction during the Eighteenth Century', in Raymond Stephanson and Darren N. Wagner (eds), *The Secrets of Generation: Reproduction in the Long Eighteenth Century* (Toronto, Buffalo and London, 2015), pp.372-373.
[699] Nelly Cameron, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/12), pp.139-140.
[700] Ibid.; Margaret Calder, *Practical Observations in Medicine by Andrew Duncan*, 1788 (DEP/DUA/1/44), pp.229-244.
[701] Diana S. Gallagher, 'Parasites and Sanitation in Eighteenth-Century Newport, Rhode Island: The Pratt, Brown, and Tate Families', *Early American Studies: An Interdisciplinary Journal*, 8:2 (2010), p.246.

dispensary. There, worm infestation was, of all digestive complaints, by a significant margin the most heavily weighted in favour of the admission of children. One hundred percent of all individuals admitted with a diagnosis of worms were aged under 14 years in 1780, 1800, and 1805.[702] While age-related data is not available for the Newcastle dispensary, the similar pattern of growth in the admission of cases of worms may imply a similar weighting in favour of child admissions.

The correlation between admission rates between the two dispensaries, although clear in the instance of worms, was not consistent across all digestive complaints. Dysentery was the condition which showed the most significant disparity in admission levels between the Kelso and Newcastle dispensaries in the late eighteenth century. Rates of dysentery remained low at the Kelso dispensary throughout the period under study (Figure 5.4). At the Newcastle dispensary, by contrast, high levels of this disease can be seen in 1780 and 1785, which respectively totalled 29.3 and 24.9 per cent of diseases of the digestive system, before reducing significantly in subsequent years (Figure 5.5). The historian Charles Creighton has asserted that Newcastle experienced rates of dysentery in the later eighteenth century which were second only to London in their virulence.[703] Supporting this proposition, an account of the Newcastle dispensary, published in 1789, detailed outbreaks of dysentery in the 'autumn of 1783, and 1785' which 'attacked great numbers of the poor'.[704] Clark discussed these incidences in his published works on epidemic disease, as well as describing an earlier outbreak in 1781 which was 'introduced into a dock-yard, in this neighbourhood, by some sailors who returned from abroad ill of the complaint'.[705] Pringle, similarly, detailed numerous cases of military men returning from overseas and bringing the contagion with them.[706] While we lack definitive evidence to prove that individual outbreaks of dysentery were introduced into Newcastle through such means, certainly that city's role as a busy port left it more open to the introduction of contagion in this manner than Kelso.

Kelso's exposure to epidemics may have been mitigated by its geographical location but, overall, the dispensary there showed higher levels of diseases of the digestive system in

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[702] *Kelso Dispensary Patient Registers*, 1780-1805 (HH71/7-8 and HH71/43).
[703] Charles Creighton, *A History of Epidemics in Britain, Volume Two* (Cambridge, 1894), pp.780-781.
[704] Anon., *An Account of the Newcastle Dispensary, for the Relief of the Poor*, p.5.
[705] Clark, *Observations on the Diseases Which Prevail in Long Voyages to Hot Countries*, *Volume Two,* pp.342-344.
[706] See, for example, *Medical Annotations by Sir John Pringle*, *Volume Five*, c.1765 (DEP/PRJ/1/5), p.365; *Medical Annotations by Sir John Pringle*, *Volume Six*, c.1767 (DEP/PRJ/1/6), pp.119-120.

the final years of the eighteenth century than Newcastle's dispensary. This was the result, in part, of the high levels of dyspepsia observed in the town. Indeed, dyspepsia was the most common disease of the digestive system at the Kelso dispensary throughout the period under study, with the exception of the year 1800 when this category was, briefly, overtaken by the admission of cases of intestinal worms (Figure 5.4). At the Newcastle dispensary, by contrast, there was not a single recorded case of this condition between 1780 and 1810. Admission levels of patients suffering from 'stomach complaints', however, remained high throughout the period. The two categories, dyspepsia and stomach complaints, show a similar pattern of growth over the course of the late eighteenth and early nineteenth centuries. It seems likely, therefore, that the broader category of stomach complaints included cases of dyspepsia, possibly alongside other, similar conditions.

The term 'dyspepsia' was often used interchangeably with indigestion in eighteenth-century medical studies.[707] In modern medical understanding dyspepsia is identified as a symptom which can indicate an underlying condition such as gastritis or gall-bladder disease.[708] In the eighteenth century it was also frequently considered to be a symptom rather than a disease in its own right, often being viewed as an indication that the patient was suffering from a nervous complaint.[709] When James Rymer, a naval surgeon, wrote on the subject of dyspepsia, he stated that the 'derangement of health termed *dyspepsy*, namely indigestion, or morbid affection of the stomach; and the hypochondriac disease, the vapours or low spirits; are distempers generally so blended with each other… and also with every affection of the system purely nervous'.[710] Dyspepsia, therefore, could be both a localised physical ailment and also a manifestation of a wider malaise. The symptoms which were associated with dyspepsia were indicative of this duality and included heartburn, stomach pain and vomiting, alongside despondency and anorexia.[711]

The perceived causes of dyspepsia were wide ranging. In his Edinburgh dispensary case notes, Duncan cited factors such as suffering from a miscarriage, exposure to cold, and

[707] See, for example, James Rymer, *A Tract Upon Dyspepsy, or Indigestion; and the Hypochondriac Disease; and Upon the Inflammatory or Regular Gout, and the Atonic, Irregular, or Flying Gout* (London, 1795), p.1.
[708] David A. Bender, *Benders' Dictionary of Nutrition and Food Technology* (Abingdon and Boca Raton, 2006), p.162.
[709] Roy Porter, 'Biliousness', in W. F. Bynum (ed.), *Gastroenterology in Britain: Historical Essays* (London, 1997), p.8.
[710] Rymer, *A Tract Upon Dyspepsy*, pp.1-2.
[711] Roy Porter, 'Biliousness', p.8.

hard labour.[712] As with many other digestive complaints, diet was also considered to be a significant cause, including the excessive eating of 'flatulent vegetables' and the drinking of hot tea.[713] The potential causes of dyspepsia which historians have proffered, however, are somewhat different. Risse has suggested that, given how common conditions like indigestion appear to have been amongst the poor, they may simply have been an indication of hunger pangs, although this was entirely speculative on his part.[714] In the case of the Edinburgh infirmary, the subject of Risse's study, levels of this condition remained constant throughout the late eighteenth and early nineteenth centuries.[715]

As this chapter has demonstrated, rates of dyspepsia and of the general category of digestive complaints show a different pattern at the Kelso and Newcastle dispensaries, with admissions increasing over the period under study. Furthermore, Jeremy Baron and Amnon Sonnenberg have used statistical evidence from private practice and dispensary records dating from the late eighteenth and early nineteenth centuries to show that there was no significant difference between the levels of dyspepsia experienced by poor patients and their richer counterparts.[716] This suggests that other factors, beyond deprivation and malnutrition, were at work. Moreover, even as dispensary admissions for digestive diseases rose over the course of the late eighteenth and early nineteenth centuries, mortality rates for these conditions declined significantly.[717] This implies that rising admission levels do not necessarily reflect an increase in the incidence of these conditions, but rather, perhaps, an increased willingness of the local population to seek dispensary treatment for relatively minor complaints.

Prior to the establishment of dispensaries, sufferers from such chronic conditions would have relied, primarily, on domestic treatments. These remedies could be sourced from publications such as *Domestic Medicine*, advocated by friends, family or neighbours.

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[712] Peggy Byres, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/12), pp.118-125; Mathew Steele, *Practical Observations in Medicine by Andrew Duncan*, December 1789 (DEP/DUA/1/47), n.p.; Janet Lyon, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/12), pp.72-n.p.
[713] Robert Mitchel, *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/14), pp.172-173; Margaret Grieve, *Practical Observations in Medicine by Andrew Duncan*, 1782 (DEP/DUA/1/29), p.23.
[714] Risse, *Hospital Life in Enlightenment Scotland*, p.147.
[715] Ibid., p.148.
[716] J. H. Baron and A. Sonnenberg, 'Alimentary Diseases in the Poor and Middle Class in London 1773-1815, and in New York Poor 1797-1818', *Alimentary Pharmacology & Therapeutics*, 16:10 (2002), p.1713.
[717] Charles Wilson, 'Statistical Observations on the Health of the Labouring Population of the District of Kelso', pp.343-344; *Kelso Dispensary Patient Registers*, 1780-1805 (HH71/7-8 and HH71/43); Anon., *Newcastle Dispensary Annual Reports* (1780-1810).

Or, as in the case of dispensary patient William Williamson, who believed that smoking tobacco 'breaks the wind upon his stomach', discovered through personal experience.[718] The services of orthodox medical practitioners would, much more rarely, have been utilised by individuals of the social and economic status of dispensary patients. Indeed, the infrequency with which dispensary patients sought the treatment of a private practitioner for such complaints is demonstrated by the entry for John Lithgow, from the summer of 1777, in the Edinburgh dispensary records.[719] In his report of this case Duncan noted, with apparent surprise, that Lithgow, who suffered from low spirits and a diseased alimentary canal, though of a 'sphere of life no higher than that of journeyman shoemaker', had taken upon himself to seek the 'opin[ion] not only of diff[erent] practit[ioners] respecting his disease but consulted also var[ious] practic[al] authors'.[720] Duncan cited Lithgow as a rare example of an individual not of wealth or social status who was able or willing to seek out the services of fee-charging medical practitioners for his digestive complaint. For chronic conditions such as these, therefore, dispensaries were commonly the primary channel through which the poor were able to access the treatment of orthodox practitioners.

5.4 Conclusion

For the sick poor of Edinburgh, Kelso, and Newcastle, access to charitable medical provision was limited prior to the establishment of dispensaries in those districts. These limitations were particularly pronounced in the context of diseases which were viewed as chronic, such as digestive conditions, and those which were perceived as having moral implications, such as venereal complaints. Dispensaries, by removing certain of the barriers to treatment which were applied by infirmaries and workhouses, were able to open admission up to those suffering from a broader range of the diseases that afflicted the general population of the towns and cities in which they were established.

Beyond these similarities, dispensary admission of certain diseases also diverged in suggestive ways. Perhaps the greatest point of divergence was in the context of genito-urinary complaints. In the case of venereal diseases, the relative anonymity provided by

[718] William Williamson, *Practical Observations in Medicine by Andrew Duncan*, 1782-1783 (DEP/DUA/1/30), p.268.
[719] John Lithgow, *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/13), pp.76-83.
[720] Ibid, p.78.

dispensaries which were located in large cities would have made them an attractive source of treatment for the poor. Some institutions, including the Edinburgh and Newcastle dispensaries, actively welcomed such cases, encouraging patients to be open concerning their condition by providing a significant level of anonymity and by removing the fear of being refused treatment. The district of Kelso, however, shows a different pattern. Rates of admission of genito-urinary cases in general, and venereal complaints in particular, remained low throughout the period under study. The evidence provided in this chapter suggests that, while the historiographical focus upon shame and morality in the context of venereal diseases played only a minor role in determining admissions to the Edinburgh and Newcastle dispensaries, in the small town of Kelso such factors could significantly inhibit admissions.

Furthermore, the late eighteenth and early nineteenth centuries were not a period of stasis. This study posits that, overall, changes in dispensary admissions took the form of a decrease in life-threatening conditions and an increase in minor ailments, including stomach complaints such as indigestion. This suggests a general increase in population health and, in addition, a greater willingness on the part of the sick poor to visit dispensaries for chronic conditions. The Edinburgh, Kelso, and Newcastle dispensaries were amongst the earliest free public dispensaries in Britain. As a result, these institutions did not have profiles, in the late eighteenth century, equivalent to those of the Edinburgh and Newcastle infirmaries, whose role had already been embedded earlier in the century in public consciousness via newspaper articles, pamphlets, and church sermons. Knowledge of the role of dispensaries, of the openness of their access, and of the range of conditions they were willing to treat is likely only to have been diffused throughout wider society in the decades following their foundation. Growing awareness by the public of the willingness of dispensaries, unlike infirmaries, to treat both minor and chronic ailments is likely to have contributed significantly to the increased admission of individuals suffering from conditions such as non-critical digestive complaints during the final years of the eighteenth century.

Chapter 6. Treatments and Outcomes

While previous chapters have uncovered innovations in diagnostic methods and changes in the understanding of disease causation over the course of the eighteenth and early nineteenth centuries it should not be assumed that these developments revolutionised methods of treatment. Instead, physicians often adapted existing remedies to apply them to new diagnoses, providing new rationales to justify the continuation of established approaches to medical treatment. While the medical theories of William Cullen may have focused more on nerves as the primary root of disease rather than the humors, he continued to advocate traditional treatments, many of which had their basis in the purging or removal of material from the body.[721] Bleeding, blistering, and bathing were commonly prescribed treatments in the eighteenth century and were all techniques which had been in use in western medicine since antiquity.

The study of eighteenth-century therapeutic techniques such as purging and bleeding has received variable analysis in the historiography. In some earlier studies, eighteenth-century uses of such treatments were characterised primarily as an unfortunate precursor to the medical advances of the nineteenth and twentieth centuries.[722] Guy Williams, for example, writing in the 1970s, dismissed eighteenth-century medicine as 'barbaric', 'crude', and 'inhumane'.[723] In some cases treatments were studied to discover whether they 'worked', a concept defined by twentieth-century understandings of medical efficacy.[724] More recently, however, these medical techniques have increasingly been considered within their contemporary context, aligned with eighteenth-century culture, society, and understandings of disease causation.[725]

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[721] Cullen wrote a medical text detailing the most common prescriptions of the period, which was divided into chapters based on the impact which these medicines had on the human body, including diuretics, cathartics, and expectorants. William Cullen, *A Treatise of the Materia Medica, Volumes One and Two* (Edinburgh and London, 1789).

[722] See, for example, Richard Shryock, 'Eighteenth Century Medicine in America', *Proceedings of the American Antiquarian Society*, 59:2 (1950), pp.275-292.

[723] Guy Williams, *The Age of Agony: The Art of Healing, c.1700*-1800 (London, 1975), p.7.

[724] This approach has often been combined with retrospective diagnosis, particularly of high-profile individuals, for example regarding the diagnosis and treatment of American President George Washington. John Brickell, 'Observations on the Medical Treatment of General Washington in His Illness', *Transactions of the College of Physicians*, 25 (1903), pp.90-93; David M. Morens, 'Death of a President', *The New England Journal of Medicine*, 341:24 (1999), pp.1845-1848.

[725] Numerous studies have focused on the geographical and cultural contexts of diseases and their treatments. See, for example, Mark Harrison, *Disease and the Modern World, 1500 to the Present Day* (Cambridge, 2004);

Broader contextual studies have often utilised the model of the medical marketplace, a term commonly taken to mean a general availability of a diverse range of sources of medical treatment (folk healers, itinerant sellers, midwives, apothecaries, and so on) in addition to physicians. This term came into common use in the historiography from the mid-1980s, with its origins particularly associated with an article by Roy Porter from that time.[726] Porter went on to write extensively on the subject and has been considered one of its foremost proponents, arguing that it demonstrated an 'unusually spectacular blossoming of commercial medicine'.[727] The term medical marketplace, however, has more recently come into question. Roy Porter, in his writing with Dorothy Porter, focused particularly on the importance of the market in the supply of medical treatment and the transaction between the individuals of the practitioner and patient.[728] By contrast, Mark Jenner and Patrick Wallis have argued for the importance of studying markets in the plural rather than the notion of a singular market, moving away from the idea of focusing primarily on individual choice.[729] Whether charitable medical relief should be included in the model of the medical marketplace remains unclear and the approach of focusing on financial transactions appears to favour wealthier members of society.[730] The entire notion of choice is considerably more complex when considered in the context of the limited economic and social resources of the sick poor.

The present chapter will add to the existing literature by seeking to uncover the differences between the treatments recommended to wealthy patients and those prescribed to the sick poor under dispensary care. It will also explore the significance of the environment in which the patient was treated, taking into consideration the restrictions dispensaries faced as a result of their providing primarily outpatient care. Initially, it will examine the lifestyle changes which were recommended to patients, considering the varying roles that exercise and bathing played in private medical care and patients receiving

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George Sebastian Rousseau, Miranda Gill, David Haycock and Malte Herwig (eds), *Framing and Imagining Disease in Cultural History* (Basingstoke and New York, 2003).

[726] Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14:2 (1985), pp.175-198.

[727] Roy Porter, *Health for Sale: Quackery in England 1660-1850* (Manchester and New York, 1989), p.43.

[728] See, for example, Dorothy Porter and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Cambridge, 1989), pp.7-11.

[729] Mark S. R. Jenner and Patrick Wallis, 'The Medical Marketplace', in Mark S. R. Jenner and Patrick Wallis (eds), *Medicine and the Market in England and Its Colonies, c.1450-c.1850* (Basingstoke and New York, 2007), pp.1-17.

[730] Ibid., p.7.

charitable relief. The analysis will then turn to physical methods of treatment, such as blistering and bleeding, examining the variation in their uses between infirmary and dispensary care. The next section will explore the prescription of medicines and how the limited financial resources of dispensaries impacted on the range of medicaments which they prescribed. Finally, this chapter will consider the medical outcomes of dispensary patients, demonstrating the inherent complexity in drawing definitive conclusions regarding the relationship between treatment and cure. Overall, this analysis will demonstrate how the distinctive nature of the outpatient provision of dispensaries impacted both on their approaches to treatment and the recording of the medical outcomes of the patients under their care.

6.1 Hygiene and Regimen

Cullen's consultation correspondence demonstrates the frequency with which therapeutic regimen such as exercise, often taking the form of horse riding, and travel to warmer climes were considered key to both the maintenance of health and the curing of illness during the later eighteenth century.[731] In the case of one patient, 28-year-old Mistress Downman of Devon, diagnosed with melancholy after the death of her brother, it was noted that for 'weeks, indeed, for some months, indulging in grief, she often shed tears during the day… she succumbed… to sorrow'.[732] Alongside the medication which Cullen prescribed for her condition he also advocated 'exercise, amusement & especially engaging the attention by new objects & new company'.[733]

Cullen also recommended Downman try bathing, a common medical treatment in the eighteenth century.[734] The historiography of therapeutic bathing has focused more on its use by wealthy patients and less on their poorer counterparts.[735] Bathing, however, was

[731] Recommendations of horse riding and overseas travel can be found repeatedly in Cullen's correspondence. See, for example, Dr Heysham, *Correspondence of William Cullen*, 21 September 1778 (DEP/CUL/1/11/56); James Preston, 18 February 1775 (DEP/CUL/1/3/88).
[732] H. Downman, *Correspondence of William Cullen*, 7 February 1774 (DEP/CUL/1/2/140a).
[733] Mr Downman, *Correspondence of William Cullen*, 14 March 1775 (DEP/CUL/1/1/5/37).
[734] Ibid.
[735] See, for example, Roy Porter (ed.), *The Medical History of Waters and Spas* (London, 1990); John K. Walton, *The English Seaside Resort: A Social History, 1750*-1914 (Leicester and New York, 1983). More recent works have discussed bathing in the context of the less wealthy members of society, although without a focus primarily on the therapeutic aspect of eighteenth-century bathing. See, for example, Katherine Ashenburg, *Clean: An Unsanitised History of Washing* (London, 2007); Virginia Smith, *Clean: A History of Personal Hygiene and Purity* (Oxford and New York, 2007). For a more detailed discussion of seventeenth- and eighteenth-

not a treatment which was reserved exclusively for the rich, although bathing for medicinal purposes by the poor rarely took place in salubrious surroundings such as those of the town of Bath. Instead it took place in local rivers, in the open sea, or in tubs in their own homes.[736] While baths which were open to the general public were erected in many towns and cities in Britain during the eighteenth century, either as private enterprises or attached to infirmaries, the fees commonly charged for their use restricted their accessibility to the poor.[737] Sea bathing, however, carried with it attendant risks. Andrew Duncan, in relation to his dispensary patients, noted on a number of occasions that they were not sufficiently robust to cope with this method of treatment, and in some instances stated that the cold water had induced the patient's illness, rather than mitigated it.[738] In the case of Margaret Grey, a patient admitted to the Edinburgh dispensary in the winter of 1781 with a diagnosis of hysteria, Duncan recommend bathing in a tub or 'form of shower bath' rather than sea bathing, because 'in deep water fatal conseq[uences] in [the] way of drown[ing] have sometim[es] hap[pened]'.[739]

It was necessary, however, for dispensary physicians to make these adaptations to therapeutic treatments in order to take into consideration the limited financial means of their charity patients. Duncan, when discussing the treatment of patients at the Edinburgh dispensary, frequently noted the techniques which he would have recommended had the patient been more wealthy. In one case dating from the winter of 1777, that of George Fife, Duncan noted that he would recommend horse riding, but the 'rank in life of our patient' would not allow for it.[740] In another instance where a patient, Alexander Ross, was suffering from chronic catarrh, Duncan observed that 'with patients of better rank nothing [is] of

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century theories on the role of bathing in medical treatment, see Elizabeth Graham, 'Pleasure and Utility: Domestic Bathrooms in Britain, 1660-1815' (Ph.D. diss., University of Edinburgh, 2013), pp.95-138.

[736] See, for example, Margaret Grey, *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/27), p.116.

[737] For a general discussion of infirmaries charging for the use of their bathing facilities, see Charles Webster, 'The Crisis of the Hospitals During the Industrial Revolution', in E. G. Forbes (ed.), *Human Implications of Scientific Advance: Proceedings of the XVth International Congress of the History of Science, Edinburgh 10-15 August 1977* (Edinburgh, 1978), p.216. Public baths were opened at the Edinburgh infirmary in the eighteenth century, with a charge made for their use. See Comrie, *History of Scottish Medicine, Volume Two*, p.452. Independent public baths were opened in Newcastle in 1781. See S. Middlebrook, *Newcastle Upon Tyne: Its Growth and Achievement* (Newcastle, 1950), pp.161-162.

[738] See, for example, Henry Johnstone, *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/27), p.38.

[739] *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/27), p.116.

[740] *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/15), pp.73-74.

more conseq[uence] in this affect[ion] than enjoying during winter [the] temperat[ure] of a comfort[able] chamb[er] or chang[ing] this clim[ate] for a warmer one'.[741] Indeed, Duncan made explicit that the limited financial resources of his dispensary patients forced him to increase his use of potent medicines in order to act as a substitute for recommending lifestyle alterations to a patient's regimen.[742] In the case of Ross, rather than having the opportunity to travel and experience other amusements, Duncan noted that he would recommend the application of blisters as well as the use of medicines which would encourage vomiting, increase urination, and promote profusive mucosal discharge.[743]

Some contemporary commentators argued that the resources of infirmaries allowed greater opportunity to manage these concerns.[744] Where patients were removed from their homes and placed in an infirmary ward it was assumed that this would enable better regulation of their cleanliness and diet than was possible under the outpatient system of dispensary provision. This was not, however, necessarily the case. Indeed, Guenter Risse has identified diminishing standards at the Edinburgh infirmary towards the end of the eighteenth century in the context of both the quality of the food provided and of general cleanliness on the wards, due, in part, to that institution's increasing financial difficulties.[745]

Furthermore, the Newcastle infirmary's visitor book, a volume which recorded complaints and comments by both patients and financial donors who were tasked with carrying out ward inspections, records a number of issues in this regard.[746] During the late eighteenth and early nineteenth centuries patients can be found complaining frequently about both the quality and quantity of the food they were given.[747] Indeed, at times the bread provided was described as having been so bad that it had the effect of 'purging some of them'.[748] In addition, one inspector of the Newcastle infirmary wards noted in 1777, with

[741] *Practical Observations in Medicine by Andrew Duncan*, 1779-1780 (DEP/DUA/1/21), n.p.
[742] Duncan discusses this, for example, in the context of a dispensary patient suffering from dyspepsia, Mary Morison. He noted that 'aid which [I have] any reason to expect must cheifly [sic] be obtain[e]d from med[icines]'. *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/11), p.34.
[743] *Practical Observations in Medicine by Andrew Duncan*, 1779-1780 (DEP/DUA/1/21), n.p.
[744] Contemporary debates regarding the relative merits of infirmary and dispensary care in this context are discussed in more detail in Croxson, 'The Public and Private Faces of Eighteenth-Century London Dispensary Charity', pp.127-149.
[745] Risse, 'Hospital History: New Sources and Methods', p.185. The financial difficulties of the Edinburgh infirmary are discussed in more detail in chapter one of this thesis.
[746] *Newcastle Infirmary House Visitors' Book*, 1763-1813 (HO/RVI/148/1).
[747] Ibid., 22 November 1780, 5 October 1795, 19 January 1796, 27 August 1799, 26 September 1799 and 14 May 1800.
[748] Ibid., 10 March 1800.

disapproval, that patients were obliged to pay for their own laundry while they were in the infirmary's care and that many of 'the poor creatures have not money to do it'.[749] This situation frequently resulted in poor hygiene on the wards, to the extent that one patient was recorded as having been 'so very dirty that the [other] patients cannot live with him'.[750]

By contrast, many dispensaries, aware of their inbuilt limitations in meeting the broader nutritional and environmental needs of their patients, by the later eighteenth century began to provide food alongside medicaments.[751] Indeed, the Newcastle dispensary, from its foundation, noted that as 'the cure of diseases depends much on proper diet, some necessary articles of this sort will be allowed by the Charity, when the patients themselves are not in circumstances to provide them'.[752] Although neither minute books nor financial records survive to allow for investigation into the scale of this provision, this statement certainly fits with the broader work which the Newcastle dispensary was undertaking during this period in relation to public health concerns, work which will be considered in more detail in chapter seven. No equivalent provision by either the Edinburgh or Kelso dispensaries has been identified. While this does not necessarily prove that such assistance was not provided, it perhaps demonstrates the variation between dispensaries in their self-identified roles in relation to wider public health and welfare issues.

6.2 Physical Methods

Dispensary physicians certainly did not view their remit as being restricted to the prescription of medicines. In addition to the therapeutic qualities of bathing and exercise, the use of physical methods of treatment, where the patient's body was manipulated by bleeding or the use of other tools and devices, has a long history in medical practice.[753] Based initially on the principles of humoral theory, where these techniques were applied in order to forcibly remove excessive humors from a patient's body, the move away from these principles over the course of the eighteenth century did not remove these treatments

[749] Ibid., 6 January 1777.
[750] Ibid., 18 January 1776.
[751] Croxson, 'The Public and Private Faces of Eighteenth-Century London Dispensary Charity', p.138.
[752] Anon., *Plan of the Newcastle Dispensary*, p.10.
[753] Harold J. Cook, 'Physical Methods', in W. F. Bynum and Roy Porter (eds), *Companion Encyclopedia of the History of Medicin*e, *Volume Two* (London and New York, 1997), pp.939-957.

from the medical practitioner's range of therapeutic options. There was variation, however, in both the method applied and extent of their use.

Bloodletting, for example, could take multiple forms. It included the application of leeches, but also cupping, by which the patient's skin was punctured and then their blood collected in a cup or other receptacle. The exact method chosen was in part down to the preference of the individual practitioner, although Duncan did note, in relation to his dispensary patients, that while he believed that the technique of cupping was more efficacious he was 'obliged to give pref[erence]' to the use of leeches, 'as from being more famil[iar] [with this] patients [are] less afraid of it'.[754] Bloodletting was used as a treatment for a range of conditions, including fever and asthma.[755] Indeed, bleeding was used by some practitioners as a treatment for conditions which had already resulted in blood loss.[756] Mary Fissell has argued that techniques such as bloodletting moved to the forefront of medical practice in charitable institutions in the later eighteenth century.[757] According to Fissell, the standardisation of treatment methods became key when institutions were dealing with patients on a large scale.[758] Bloodletting certainly remained a popular technique at public medical institutions well into the nineteenth century.[759]

Bleeding was not, however, without its critics. Rather than a focus on rebalancing humors, by the late eighteenth century the argument for this technique was that it reduced tension and prevented spasms and, indeed, the removal of large quantities of blood could be observed to have a temporary calming effect on patients.[760] Regardless of the rationale applied, increasingly, towards the end of the eighteenth century, many practitioners who were involved in medical research and education warned against the overuse of bloodletting and the importance of being selective, both in terms of deciding which diseases it was appropriate to treat by this method and also regarding the physical condition of the

[754] James Gibson, *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/27), p.151.
[755] William Cullen, *First Lines of the Practice of Physic, Volume One* (Philadelphia, 1792), p.199; Cullen, *First Lines of the Practice of Physic, Volume Two*, pp.200-201.
[756] Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol*, pp.159-160.
[757] Ibid.
[758] Ibid.
[759] Marland, *Doncaster Dispensary*, p.52. For a discussion on the decline of bloodletting over the course of the nineteenth century, see K. Codell Carter, *The Decline of Therapeutic Bloodletting and the Collapse of Traditional Medicine* (New Brunswick, 2012).
[760] *Hospital Life in Enlightenment Scotland*, p.203.

patient.[761] Cullen, for example, emphasised the 'exhausting and weakening' effect which this treatment had on many individuals.[762] Clark and Duncan were also vocal in their opposition to the widespread use of bloodletting. While neither individual entirely discounted the efficacy of bleeding in certain cases, both rarely put this method into practice. Indeed, Clark wrote, in the context of one of his studies of fever cases, that he usually chose not to bleed his patients and emphasised that 'I never lost a patient from the omission'.[763] Duncan, similarly, observed that the use of bloodletting techniques for 'much [the] great[e]r number of cases are by no means suited' and there was 'great reason to suspect that very prof[use] bloodletting' could have the outcome of 'inducing [an] atonic [state]'.[764]

Bleeding was not the only physical method of treatment in use during this period which had its origins in humoral theory and, while its use began to be questioned, other methods remained, for many physicians, integral components of their therapeutic regimen. Blistering, for example, was a common method of treatment well into the nineteenth century.[765] Once again, notions regarding the function of this treatment were revised over the course of the eighteenth century, moving from a focus on the expulsion of humors to the idea that the application of blisters acted as a stimulant.[766] The process of blistering commonly entailed the application to a patient's skin of a plaster which was coated with an irritant, such as mustard or onion.[767] The resulting blister was then either left to heal or could be continually irritated to create a constant weeping sore, known as an 'issue'.[768]

Clark displayed some reservations about the use of blistering techniques, stating that 'I am very far from being an advocate for their general use… they too frequently produce bad effects'.[769] Duncan, by contrast, although demonstrating reservations about the use of bloodletting, had no such qualms about the use of blistering techniques on his dispensary patients. He used blistering to treat a wide array of conditions which he encountered in his

[761] For a more detailed analysis of the debate over the therapeutic efficacy of bloodletting, see Peter H. Niebyl, 'The English Bloodletting Revolution, or Modern Medicine before 1850', *Bulletin of the History of Medicine*, 51:3 (1977), pp.464-483.
[762] Cullen, *First Lines of the Practice of Physic, Volume Two*, p.201.
[763] Clark, *Observations on Fevers, Especially Those of the Continued Type*, p.24.
[764] John McInnes, *Practical Observations in Medicine by Andrew Duncan*, 1777-1778 (DEP/DUA/1/16), p.88.
[765] Marland, *Doncaster Dispensary,* pp.52-53.
[766] Risse, *Hospital Life in Enlightenment Scotland*, p.210.
[767] Ibid.
[768] Ibid.
[769] Clark, *Observations on Fevers, Especially Those of the Continued Type*, pp.28-29.

dispensary practice, from respiratory complaints, rheumatism, and fungal infections to paralysis.[770] Blistering, however, was a particularly unpopular method of treatment amongst dispensary patients and the prescription of blisters often resulted in either a patient's refusal to accept that method of treatment or their ceasing attendance altogether.[771] The reasons for the lack of enthusiasm of patients towards this method of treatment are unclear, but may simply have resulted from the pain and irritation attendant on having a constant weeping sore on their body. Indeed, Risse has noted that blistering was so unpopular amongst Edinburgh infirmary patients that Cullen would use the threat of its application to pressure those patients who he felt were feigning their illnesses into leaving the infirmary.[772]

Blistering was not the only form of physical treatment which proved contentious amongst dispensary patients; the use of electricity also met with considerable opposition. Over the course of the eighteenth century, electricity became a subject of fascination and of both public and private entertainment.[773] The use of electricity for medical purposes began to be studied in the 1740s and, by the 1770s, it was considered by many to be a standard component of a physician's medical practice.[774] The use of therapeutic electricity was particularly focused on nervous conditions although, as discussed previously, medical theory on nerves in the eighteenth century was not restricted to diagnoses such as hysteria or melancholy, but also included conditions such as epilepsy and asthma.

All three dispensaries under consideration here owned electrical machines and, indeed, as mentioned in chapter two, at the Newcastle dispensary a special room was set aside for the electrification of patients. Electrical machines could take a variety of forms, commonly involving a glass jar which collected the electrical charge, known as a Leyden jar,

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[770] Robert Hunter, *Practical Observations in Medicine by Andrew Duncan*, 1778-1779 (DEP/DUA/1/19), pp.18-32; Robert Winter, *Practical Observations in Medicine by Andrew Duncan*, 1779 (DEP/DUA/1/20), pp.103-n.p.; John Omond, *Practical Observations in Medicine by Andrew Duncan*, 1780-1781 (DEP/DUA/1/25), pp.113-123; Mary Walker, *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/28), pp.89-110.
[771] See, for example, Helen Brown, *Practical Observations in Medicine by Andrew Duncan*, 1779-1780 (DEP/DUA/1/22), pp.171-181.
[772] Risse, *Hospital Life in Enlightenment Scotland,* p.211.
[773] Paola Bertucci, 'Sparks in the Dark: The Attraction of Electricity in the Eighteenth Century', *Endeavour*, 31:3 (2007), pp.88-93.
[774] Paola Bertucci, 'Therapeutic Attractions: Early Applications of Electricity to the Art of Healing', in Harry Whitaker, C. U. M. Smith and Stanley Finger (eds), *Brain, Mind and Medicine: Essays in Eighteenth-Century Neuroscience* (New York, 2007), pp.271-281.

and a hand crank which caused the necessary friction to build the static charge.[775] Electricity could be administered to the patient in a number of different ways. It could be applied to the patient's whole body using a technique known as 'insulation', whereby an electrical charge was applied to a chair, bench, or bed which the patient was reclining on.[776] It could also be introduced more locally to the patient's body through shocks or sparks created by transferring the electricity to the patient via a metal conductor, which would either be placed upon the skin or grasped in the patient's hand.[777] Devices could be small enough to be easily carried around or large, immobile pieces of equipment.[778] While neither detailed descriptions nor illustrations exist for the particular devices owned by the dispensaries, we do get an insight into their use in Kelso through the minuted regulation that the dispensary's surgeons must always have 'the assistance of the Porter to drive the wheel', a statement which certainly implies the use of a substantial machine.[779]

Duncan was extremely enthusiastic about the use of electricity on his dispensary patients. Indeed he noted that 'a good electr[icity] machine [is] a part of medic[al] appar[a]t[us] which every practit[ioner] should possess'.[780] He used the Edinburgh dispensary's electrical machine on a range of conditions, including tumours and sore necks, and believed it could restore failing eyesight and encourage menstruation.[781] The enthusiasm of the practitioner, however, was not matched by equivalent enthusiasm on the part of the patient and, as with blistering, it was regularly recorded that patients at the Edinburgh dispensary were 'much afraid of it'.[782] Whether this was simply a fear of the unfamiliar, or whether the treatment caused them significant pain, is unclear.

In one case where the patient, Mary Dod, was initially willing to submit to the electricity as a treatment for her breast cancer, Duncan noted that not only was he 'intent

[775] W. Cameron Walker, 'The Detection and Estimation of Electric Charges in the Eighteenth Century', *Annals of Science*, 1:1 (1936), pp.66-100.
[776] For a more detailed description regarding the design of eighteenth-century electrical machines, see Françoise Zanetti, 'Curing with Machines: Medical Electricity in Eighteenth-Century Paris', *Technology and Culture*, 54:3 (2013), pp.503-526.
[777] Ibid.
[778] Ibid.
[779] *Kelso Dispensary Minute Book*, 13 October 1788 (HH71/1).
[780] John Lenin, *Practical Observations in Medicine by Andrew Duncan*, 1778-1779 (DEP/DUA/1/18), p.77.
[781] Janet Brown, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/11), pp.20-30; Elizabeth Turnbull, *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/27), pp.60-72; William Brown, *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/13), pp.160-163; Grizel Craig, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/12), pp.38-45.
[782] Mary Monro, *Practical Observations in Medicine by Andrew Duncan*, 1779-1780 (DEP/DUA/1/22), pp.14-15.

to persist in [the] use of this remed[y] for [a] consid[erable] time' but also that he would 'carry it to as great [a] height as [the] patient could easily bear it' and, indeed, he then 'ordered both [the] number & sever[ity] of [the] shocks to be encreased'.[783] Dod's subsequent refusal to continue with this method of treatment forced Duncan, once again, to turn to medication as a substitute for his chosen treatment.[784] Fear was not the only inhibiting factor, however, and in another case, that of William Bailey, admitted to the Edinburgh dispensary in the winter of 1776 with paralysis of the eye, his electricity treatment was discontinued for a different reason.[785] This patient 'lived at [a] distance' from the dispensary and therefore every time he was 'electrif[ied] [he was] obliged to walk in many miles from [the] country'.[786] As a result, in this case Duncan's preferred method of treatment was replaced with a course of mercury.[787]

Dispensaries, therefore, were restricted by a number of factors in the range of therapeutic methods available to them. Not only would patients sometimes, as in the case of Dod, refuse to accept the treatments which they were prescribed but in some instances they lived at too great a distance from the dispensary to be able to make the regular visits needed to apply electricity or other physical therapeutic treatments. As a result, while data does not exist to provide an accurate statistical comparison between the treatment methods of dispensaries and infirmaries, it appears that dispensaries were, by necessity, more reliant on medicaments than their infirmary counterparts.

6.3 Medicinal Methods

Fissell, as previously noted, has emphasised that the Bristol infirmary was increasingly focused on the use of physical treatments during the later eighteenth century. Risse, similarly, has found that expenditure on medicaments at the Edinburgh infirmary decreased during this period.[788] While the Edinburgh infirmary established its own physic garden, which enabled it to provide medicines at a lower cost, Risse has postulated that this decline

[783] *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/12), pp.18-19.
[784] Ibid., p.19.
[785] *Practical Observations in Medicine by Andrew Duncan*, 1776 (DEP/DUA/1/12), pp.142-145.
[786] Ibid., pp.144-145.
[787] Ibid., p.145.
[788] The downturn in expenditure observed by Risse was not per patient, but was an overall reduction, in spite of an increase in patient admissions during this period. Risse, 'Hospital History: New Sources and Methods', p.177.

in expenditure may also have been due to changes in medical practice, with an increased focus on physical, rather than medicinal, treatments.[789] The increased financial difficulties faced by the Edinburgh infirmary may also have had an impact on the treatment models which were adopted. By contrast, the financial data which survives for the Kelso and Newcastle dispensaries demonstrates no equivalent downturn in expenditure on medicaments by those institutions.[790] This suggests that the therapeutic approaches identified by Fissell and Risse as the mainstay of infirmaries during this period were not replicated by their dispensary counterparts.

There is no indication that the Edinburgh and Newcastle dispensaries developed their own physic gardens in the eighteenth century. The Kelso dispensary did, however, record payments made to a gardener, beginning in 1790.[791] This introduction coincided with the move of the dispensary to a larger property and its establishing an inpatient facility.[792] As there is no mention of a physic garden in any of the dispensary's records and there was no reduction during this period of the cost of their medications it cannot be assumed that this gardening work was necessarily carried out in relation to a physic garden. Perhaps the garden was established for purely aesthetic reasons, or perhaps it was a source of food for those admitted to the newly opened inpatient ward.

As a result of the lack of dispensary physic gardens, the majority of the medicines which they prescribed had to be purchased. The geographical location of the dispensaries does not appear to have had a significant impact on the source of their medications, with records demonstrating that both the Kelso and Newcastle dispensaries ordered drugs from London.[793] Although it cannot be ruled out that they also purchased additional medications more locally, the surviving records for both institutions appear to indicate that London was their primary source. Indeed, in the case of Kelso, while initially medications were ordered from Newcastle, in 1781 it was decided that these had 'proved inert and incapable of

[789] Ibid.
[790] Anon., *Kelso Dispensary Annual Reports* (1778-1810); Anon., *Newcastle Dispensary Annual Reports* (1777-1810).
[791] Anon., *Kelso Dispensary Annual Report* (1790), p.11.
[792] Dispensary accommodation is discussed in more detail in chapter two.
[793] *Bill for medicines purchased from Corbyn, Brown, Beaumont and Stacey of Holborn by the Newcastle Dispensary*, 1782 (WL, MS.5440/1); *Kelso Dispensary Minute Book*, 1 October 1781 (HH71/1).

producing any good affect' and that in future supplies should instead be purchased from the Apothecaries' Hall in London.[794]

Individual dispensaries developed their own methods of funding and procuring the medicines which they needed. As previously noted in chapter two, at the Edinburgh dispensary the fees paid by the medical students who attended classes at the dispensary were set aside specifically for purchasing drugs. At the Kelso dispensary, initially subscribers were obliged to pay additional funds, on top of their subscriptions, to cover the cost of the medicines which the dispensary required.[795] It was also not uncommon for medical charities to request donations and to receive gifts of medical items. The Kelso dispensary, for example, was gifted with some glass medicine bottles in 1778 and, in 1799, put out a call for donations of linen rags for use on patient wounds.[796] Additionally, the Edinburgh dispensary received donations of medicines from such distant locations as St. Petersburg.[797] This particular gift, a parcel of Rhododendron chrysanthemum which was a treatment commonly used for rheumatism, was from a Dr Guthrie, whom Duncan had previously been in correspondence with regarding his research.[798] Personal and professional connections such as these enabled the Edinburgh dispensary to trial the use of more exotic medicines which would otherwise have been beyond its financial means.

Which medications were prescribed was, of course, dictated not only by resources, but also by the medical diagnoses of the patients who were being treated. The exclusion of certain medical conditions from infirmaries, detailed in chapter two, influenced the treatments which were applied. This included, in the case of the Newcastle infirmary, the barring of individuals suffering from infectious conditions such as fevers. The Edinburgh, Kelso and Newcastle dispensaries witnessed high levels of fever patient admissions in the later eighteenth century, a subject discussed in more detail in chapter seven, and, correspondingly, medicaments which were considered to be effective treatments for these conditions were used extensively. One of the most common medicines used in cases of fever was Peruvian bark, also known as Cinchona or Jesuit's bark, which was introduced to

[794] *Kelso Dispensary Minute Book*, 1 October 1781 (HH71/1).
[795] 'Plan for Establishing A Public Dispensary at Kelso For the Relief of The Indigent', *Kelso Dispensary Minute Book* (HH71/1).
[796] *Kelso Dispensary Minute Book*, 1 May 1778 and 3 October 1799 (HH71/1).
[797] William Stark, *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/28), pp.15-17.
[798] Ibid.

Europe in the seventeenth century.[799] This medicament, which contained quinine, was a common treatment for intermittent fever. Peruvian bark was also used by the Edinburgh dispensary to treat a wide range of other conditions, from epilepsy, to headaches and rheumatism.[800] The quinine component of the bark was only isolated in 1820 so, in the late eighteenth century, while Peruvian bark was known to be effective in some cases of fever, it was a matter of some discussion and debate as to precisely how it worked and which other conditions it could be used to treat.[801]

Peruvian bark was commonly prepared in powder form and then mixed with water, alcohol, syrup or other medicaments.[802] As the name implies, it was originally extracted from trees which grew in South America.[803] The difficulty of maintaining a steady supply of this material to meet the demand by European medical practitioners meant that, as early as the seventeenth century, counterfeit samples began to circulate.[804] Moreover, there was no robust way to test the material to identify if it was true Peruvian bark or simply a substitute which had no medicinal properties whatsoever.[805] Duncan warned that usually 'the Phys[ician] in gener[al] does very little. For cont[enting] himself with prescr[ibing] bark [he] leaves [the] choice entirely to [the] Apoth[ecary]'.[806] And, by such means, there 'can be no doubt that [the] effic[acy] of [the] prescrip[tion] often disapp[ears]'.[807]

Duncan criticised the Apothecaries' Hall in London for purchasing only the cleanest bark, without matter adhering to its surface, and emphasised that by doing so they were

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[799] Wouter Klein and Toine Pieters, 'The Hidden History of a Famous Drug: Tracing the Medical and Public Acculturation of Peruvian Bark in Early Modern Western Europe (c.1650-1720)', *Journal of the History of Medicine and Allied Sciences*, 71:4 (2016), pp.400-421.

[800] James Lind, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/11), pp.105-n.p.; Betty Brown, *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/12), pp.57-61; Robert Carfrae, *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/28), pp.79-87.

[801] For more detail on the isolation of quinine, see M. R. Lee, 'Plants Against Malaria. Part 1: Cinchona or the Peruvian Bark', *The Journal of the Royal College of Physicians of Edinburgh*, 32:3 (2002), pp.192-193. For discussions on the potential range of therapeutic efficacies of Peruvian bark, see Cullen, *A Treatise of the Materia Medica, Volume Two*, pp.89-114; Andreas-Holger Maehle, 'Four Early Clinical Studies to Assess the Effects of Peruvian Bark', *Journal of the Royal Society of Medicine*, 106:4 (2013), pp.153-154.

[802] Many examples detailing the preparation process for Peruvian bark can be found within Cullen's correspondence. See, for example, William Ingham, *Correspondence of William Cullen*, 8 June 1783 (DEP/CUL/1/1/16/48); Henry Richardson, 23 March 1780 (DEP/CUL/1/1/12/155).

[803] Lee, 'Plants Against Malaria', pp.189-190.

[804] Ibid., p.191.

[805] Ibid.

[806] Francis Cruikshank, *Practical Observations in Medicine by Andrew Duncan*, 1782-1783 (DEP/DUA/1/30), p.91.

[807] Ibid.

acquiring a product which 'cannot be supposed to possess any medic[al] virtue' because 'bark in this clean state, [is] less powerful than the other'.[808] The most potent bark, according to a 1782 study by the physician William Saunders, was red Peruvian bark which had been transported directly by Spanish ships from Peru.[809] This was, however, difficult to come by and Duncan, in 1782, described how, some years previously, this red bark had been imported into Edinburgh and sold to a number of local apothecaries, implying by this statement that this was an unusual occurrence and that this medicament was not commonly available in that city.[810] Clark, in his work on fevers, also wrote strongly in favour of the use of Peruvian bark.[811] While it is not possible to determine the relative efficacy of the different barks prescribed by each institution, the emphasised importance of acquiring unadulterated bark as directly as possible from its source may have been facilitated in the case of the Newcastle dispensary by its proximity to a busy city port.

Identifying more local substitutes for Peruvian bark was of great interest to practitioners and a range of alternatives, including charcoal as well as the bark of other, more locally available, trees were experimented with.[812] Patients at the Edinburgh dispensary were trialled with alternatives such as these, although Duncan was not optimistic about their efficacy.[813] Duncan also experimented on his dispensary patients with another substitute for Peruvian bark, called 'infallib[le] tasteless ague drops', an item that he described as 'what some would, entit[le] a quack med[icine]'.[814] While he found this to be an effective treatment, Duncan registered concern about its high cost.[815] As a result, when treating Barbara Dunn, who was admitted into the Edinburgh dispensary in 1788 with an intermittent fever, the ague drops were substituted for a remedy that was a combination of

[808] Ibid., pp.91-92.
[809] William Saunders, *Observations on the Superior Efficacy of the Red Peruvian Bark, in the Cure of Agues and Other Fevers. Interspersed with Occasional Remarks on the Treatment of Other Diseases, by the Same Remedy* (London, 1782).
[810] Francis Cruikshank, *Practical Observations in Medicine by Andrew Duncan*, 1782-1783 (DEP/DUA/1/30), p.94.
[811] Clark, *Observations on Fevers, Especially Those of the Continued Type*, pp.22-27.
[812] Maehle, 'Four Early Clinical Studies to Assess the Effects of Peruvian Bark', pp.151-153; Dr Makesy, 'On the Use of Charcoal, as a Substitute for Peruvian Bark', *The New England Journal of Medicine, Surgery and Collateral Branches of Science*, 4:2 (1815), pp.105-108; Cullen, *A Treatise of the Materia Medica, Volume Two*, pp.72-89, pp.114-115; Pratik Chakrabarti, 'Empire and Alternatives: Swietenia Febrifuga and the Cinchona Substitutes', *Medical History*, 54:1 (2010), pp.75-94.
[813] Peggy McGlashan, *Practical Observations in Medicine by Andrew Duncan*, 1778 (DEP/DUA/1/17), p.154.
[814] Francis Cruikshank, *Practical Observations in Medicine by Andrew Duncan*, 1782-1783 (DEP/DUA/1/30), p.99.
[815] Barbara Dunn, *Practical Observations in Medicine by Andrew Duncan*, 1788 (DEP/DUA/1/45), pp.125-126.

arsenic, distilled water, and vegetable alkali, which was a potassium compound.[816] Although acknowledging that he employed it with 'great timid[ity]' Duncan believed it was 'cert[ainly] not less effic[acious]' than the medicine which it replaced.[817]

This was not the only instance where factors of availability combined with considerations of cost to put a commonly prescribed medicine out of the reach of charitable institutions. Indeed, Duncan noted that it had 'often been regre[t]ted that many foreign artic[les] [are] used in med[ical] [practice] while subst[itutes] of equal if not sup[erio]r powers [are] every day before [our] eyes'.[818] Another treatment commonly prescribed in private practices such as Cullen's was Sarsaparilla, a sudorific which, like Peruvian bark, was derived from a South American plant.[819] While not questioning its efficacy, Duncan noted that 'to this artic[le] the high price [is] an objection in [a] practice conduct[ed] on [such a] footing [as] of ours'.[820] As a result other, cheaper, methods of inducing perspiration in patients were used.[821]

While it is outside the scope of this study to consider the contents of such commonly prescribed medicines to determine their active components, it should be considered whether eighteenth-century dispensary practitioners considered these therapeutic methods to be efficacious. It cannot be assumed that, just because a particular treatment was commonly prescribed, this means it was generally believed to work. Duncan, in his dispensary practice, on a number of occasions questioned the efficacy of his treatments.[822] In addition, in the Edinburgh dispensary records the term 'placebo' was occasionally used in relation to the treatments prescribed, with Duncan noting that the medicine was being

[816] Ibid., pp.125-127.
[817] Ibid., pp.126-127.
[818] Peggy McGlashan, *Practical Observations in Medicine by Andrew Duncan*, 1778 (DEP/DUA/1/17), p.153.
[819] For examples of Cullen's prescription of Sarsaparilla, see Lauchlan Campbell, *Correspondence of William Cullen*, 27 July 1780 (DEP/CUL/1/1/13/49); John Short, 30 January [1778] (DEP/CUL/1/1/10/65). For more information on the importation of Sarsaparilla, and other South American medicinal plants, see Stefanie Gänger, 'World Trade in Medicinal Plants from Spanish America, 1717–1815', *Medical History*, 59:1 (2015), pp.44-62.
[820] Turnbull Carmichael, *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/14), p.147.
[821] There were many alternatives to Sarsaparilla available, and Cullen devoted seven pages of one of his medical texts to discussing a range of other sudorifics. Cullen, *A Treatise of the Materia Medica, Volume Two*, pp.579-585.
[822] A common phrase used by Duncan in relation to his treatment methods of dispensary patients was that they would be applied on a 'rand[om] & empyr[ical] footing [rather] than on rational prin[ciples]'. Where he noted that 'respect[ing] [a] plan of cure [I] was very much at [a] loss', this did not dissuade him from prescribing a range of treatments. Janet Allan, *Practical Observations in Medicine by Andrew Duncan*, 1779-1780 (DEP/DUA/1/22), p.3.

given 'to induce [the patient] to regul[ar] attend[ance], [rather] than as [a] means of cure'.[823] The difficulties which dispensaries faced in encouraging patients to continue their visits meant that if physicians, such as Duncan, were interested in studying their patients and identifying the outcomes of their cases, then prescribing superfluous medicines could be a useful method to ensure regular attendance.

6.4 Medical Outcomes

The relationship between the patient outcomes recorded in the eighteenth century by charitable institutions and any notion of these institutions having facilitated a medical cure was not a simple one. In addition to the questions which contemporaries raised regarding the efficacy of some of the treatments which were prescribed, dispensaries were also confronted with the difficulty of keeping track of individuals who were treated under outpatient care. Indeed, in some cases these challenges have guided the focus of the literature on eighteenth-century medical institutions, with the historian Steven Cherry emphasising that his chosen research focus of inpatient rather than outpatient data was determined by the perceived lack of reliability of the latter.[824]

There were various factors, however, which could create inaccuracies in eighteenth-century data on patient outcomes, even in the context of the apparently more reliable inpatient records. Risse has noted, in the context of the Edinburgh infirmary, how patient information was initially transcribed into an admissions book, and once the patient was admitted, into individual ward journals, which were then summarised into ward ledgers, then information from all three of these sources was compiled into a central patient register.[825] The number of steps this entailed, and the number of different individuals whom this process relied upon, inevitably resulted in omissions and errors in the final data.[826] In his analysis of patient outcomes, Risse acquired his data from a number of contemporary

[823] Margaret Grey, *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/27), p.114. Other examples of cases where Duncan described patient prescriptions as placebos include: James Mitchell, *Practical Observations in Medicine by Andrew Duncan*, 1781-1782 (DEP/DUA/1/27), n.p.; Peter McDougall, 1778 (DEP/DUA/1/17), p.42.
[824] S. Cherry, 'The Hospitals and Population Growth: Part 1 The Voluntary General Hospitals, Mortality and Local Populations in the English Provinces in the Eighteenth and Nineteenth Centuries', *Population Studies*, 34:1 (1980), p.62, note 19.
[825] Risse, *Hospital Life in Enlightenment Scotland*, pp.43-56.
[826] Ibid., pp.45-49.

sources, including patient registers and annual summaries which were published in *The Scots Magazine*.[827] The difficulties in using a multitude of sources within a single analysis are demonstrated by selecting two years, 1775 and 1780, where the numbers Risse gives in his work are taken from *The Scots Magazine*. Regarding both those years, the figures reported as cured in this published source were higher than those found in the original registers. For the year 1775, 1560 individuals were categorised as cured in the printed summary, while 1533 were recorded as cured in the corresponding infirmary patient register.[828] Similarly, in 1780, *The Scots Magazine* detailed 1358 patients as having being cured, while the register recorded only 1318.[829] While the latter numbers are similar enough to perhaps have simply been the result of a typographical error, the former is more curious and could reflect human error in adding up the totals, or could imply that the number of patients categorised as having been cured was intentionally inflated in the print edition. Risse, therefore, included sources of ranging reliability and accuracy within a single table without highlighting that this was potentially problematic.

When considering the reliability of data such as this, however, we must consider the purposes for which it was created. The summaries of the patient outcomes of charitable institutions which were printed in annual reports and newspapers helped to justify the work of those institutions, to governors, potential donors, and to a broader audience, lending them greater credibility and status.[830] While Cherry has argued that 'the overall impression is that the hospitals did not usually make false claims', studies which rely entirely on printed summaries are unable to demonstrate the veracity of this statement.[831] Where comparison can be made between manuscript and printed material, as in the case of the Edinburgh infirmary, this can tell a different story. The significance of the publication of these statistical results being, in part, for promotional purposes should not be ignored.

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[827] Ibid. It should be noted, however, that elsewhere in his study Risse carried out statistical analysis covering a shorter period of time which was based on the data in the patient registers. See Risse, *Hospital Life in Enlightenment Scotland*, pp.228-239.

[828] *The Scots Magazine*, January 1776, p.56; *Royal Infirmary of Edinburgh General Register of Patients*, 1774-1775 (LHSA, LHB1/126/5).

[829] *The Scots Magazine*, December 1780, p.715; *Royal Infirmary of Edinburgh General Register of Patients*, 1778-1780 (LHB1/126/7).

[830] For a more detailed discussion concerning the promotion and funding of infirmaries, see chapter one of this thesis.

[831] Cherry, 'The Hospitals and Population Growth', p.62.

Ensuring positive publicity was certainly not the only aim of institutions when compiling information on patient outcomes. Clark's collecting of patient data, a subject which will be discussed in more detail in chapter seven, was particularly thorough. His focus was less on the usefulness of statistical data for promotional purposes and more on the study of mortality rates and the effectiveness of particular treatments.[832] In an attempt to ensure the accuracy of its data the Newcastle dispensary added punitive measures to encourage individuals who discharged themselves to report back regarding their health, stating that if they ceased attending without doing so they would be barred from future admission.[833] However, the difficulty in persuading former patients to report on their condition is made clear by the notes of Duncan, which record the case of 22 year old Patrick McCullough, admitted to the Edinburgh dispensary in the winter of 1789 with symptoms which included the coughing up of blood.[834] After being treated for a few weeks McCullough 'never again attended in this place'.[835] Duncan assumed that this was due to him no longer needing medical attention, because he 'may be seen daily in [the] streets following [the] occup[ation] of Hawker'.[836] Indeed, Duncan determined his dispensary patients' medical outcomes on a number of occasions based on having seen them on the streets of Edinburgh and surmising, in some cases without exchanging any words with them, that they appeared to be healthy.[837]

It was a bold assumption, however, to conclude that a patient's ceasing their attendance was necessarily an indication of their good health as there was a range of other reasons why a patient might quit the dispensary. In some instances, as previously discussed, patients were either put off by the particular method of treatment which they were prescribed or they lived at a great distance from the dispensary and so simply found themselves unable to make the regular visits necessary to receive ongoing treatment. They may also have left the dispensary's care to pursue other treatment options, whether

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[832] U. Tröhler. 2003. *John Clark 1780 & 1792: Learning From Properly Kept Records* [Online]. JLL Bulletin: Commentaries on the History of Treatment Evaluation. Available at: http://www.jameslindlibrary.org/articles/john-clark-1780-1792-learning-from-properly-kept-records/ [Accessed: 28 November 2019].
[833] Anon., *An Account of the Newcastle Dispensary, for the Relief of the Poor*, p.11.
[834] *Practical Observations in Medicine by Andrew Duncan*, 1789 (DEP/DUA/1/47), n.p.
[835] Ibid.
[836] Ibid.
[837] Margaret Drummond, *Practical Observations in Medicine by Andrew Duncan*, 1784 (DEP/DUA/1/35), p.268; Peter McDairmid, *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/13), p.117.

seeking admission to an infirmary or workhouse or making use of community support systems, domestic treatments, or self-help insurance organisations, known as friendly societies.[838] Or, most likely, an individual would pursue a combination of these options. A patient leaving the dispensary's care before their treatment was formally concluded could, therefore, be an indication of frustration at the treatment they had received rather than of its success.

Many historians have grappled with the difficulty of finding meaning in the data reported by eighteenth-century institutions on their patient's medical outcomes.[839] Cherry, in the context of his study of charitable hospitals during this period, has stated that we must, by necessity, assume that patients who were designated as cured were 'fully recovered' and that those categorised as relieved had received some benefit from their treatment.[840] In addition to the previously mentioned possibilities of intentional distortions and accidental errors in the recording of data, it cannot be assumed that eighteenth-century practitioners understood terms such as 'cured' or 'relieved' to have the same meaning as they would in a modern context. Rarely is it possible to make a comparison between the blunt terms used in annual reports and more detailed descriptions of the conclusion of a patient's medical treatment. In the case of the Edinburgh dispensary, however, the two annual reports which survive for that institution give the names of the patients next to their recorded outcomes.[841] This enables comparison between the terms used in print and the handwritten dispensary case notes. Across the period covered by these annual reports, November 1776 to November 1778, the outcomes recorded were: 300 patients cured, 8 dead, 176 described as 'no better', 167 whose conditions were relieved, and 82 patients whose treatments continued into the following year.[842]

These bare descriptions, however, could serve to disguise a multitude of outcomes. The designation of cured, for example, was not as unequivocal in its meaning as the term initially may appear. When Sarah Mills was dismissed from the care of the Edinburgh

[838] For a more detailed discussion regarding these sources of medical treatment for the poor, see chapter one of this thesis.
[839] Marland, *Doncaster Dispensary*, pp.59-61; Risse, *Hospital Life in Enlightenment Scotland*, pp.228-239; Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol*, pp.107-108.
[840] Cherry, 'The Hospitals and Population Growth', p.62.
[841] Duncan, *A General View of the Effects of the Dispensary at Edinburgh. During the First Year of that Charitable Establishment*, pp.7-15; Anon., *A General View of the Effects of the Dispensary at Edinburgh. During the Second Year of that Charitable Establishment*, pp.9-25.
[842] Ibid.

dispensary in January 1777, after two months of treatment for her rheumatic symptoms, her case was recorded in the dispensary's annual report as 'cured'.[843] In Duncan's notes, however, he described how she had been returned to 'tolerable health' but went on to question whether she 'might again be subj[ect] to [a] renewal of [the] compl[aint]' and stated that it was 'not improbab[le] that [she] may again apply for assist[ance]'.[844] The description of an individual as cured, therefore, could indicate a temporary cessation of symptoms, rather than the expectation of a permanent, or even long term, resolution of a condition.

The application of the term 'cured' should also not be taken as an indication that the activity of the dispensary necessarily played a role in an individual's health outcomes. This can be related to the previous discussion of contemporary understanding of the effectiveness of certain treatments, but should also be considered in the context of the tendency of certain medical conditions to resolve themselves. In the case of John McLean, who was admitted into the Edinburgh dispensary in May 1777 suffering from fever-like symptoms, he was dismissed two weeks later as cured.[845] Duncan later acknowledged that, while the medicines he had prescribed may have been of some benefit, McLean's condition had in 'some measure natural[ly] termin[ated] in [a] fav[ourable] manner'.[846] The outcome of cured, therefore, could be used to mean that the individual's symptoms had abated, without there necessarily being any indication that the dispensary and its treatments had played a significant role in this.

Another outcome which was frequently recorded was 'relieved', a term which, while it could indicate a reduction in the patient's symptoms, was also used to categorise individuals who had simply stopped attending the dispensary. One such case was that of Robert Robertson, a patient who was treated by the Edinburgh dispensary's staff in the summer of 1777 for a discharge of pus from his ear and who attended only once before quitting the institution.[847] Even though the outcome of Robertson's condition was

[843] Duncan, *A General View of the Effects of the Dispensary at Edinburgh. During the First Year of that Charitable Establishment*, p.7.
[844] *Practical Observations in Medicine by Andrew Duncan*, 1776-1777 (DEP/DUA/1/11), p.181.
[845] Duncan, *A General View of the Effects of the Dispensary at Edinburgh. During the First Year of that Charitable Establishment*, p.10; *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/14), pp.67-75.
[846] *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/14), p.75.
[847] *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/14), pp.130-134.

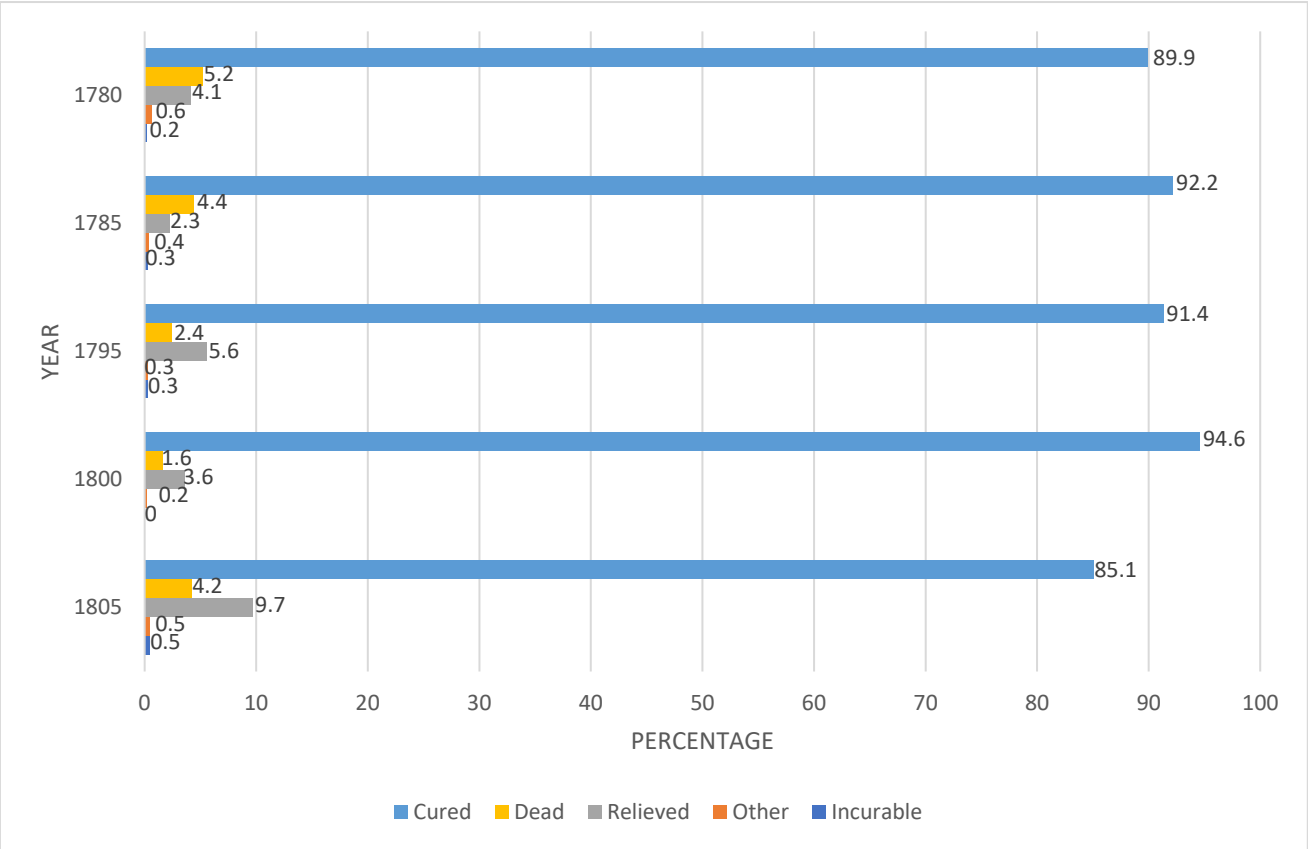
designated in the dispensary's annual report as having been relieved, Duncan wrote that 'whether [he] has left us because these [symptoms are] relieved or from any other reason [I] do not know'.[848] A similar case was that of Jean Taylor, admitted into the Edinburgh dispensary in the summer of 1778 suffering from pains in her chest, ears, and head.[849] After being treated with blisters and squill pills, a herbal expectorant, she soon ceased attending at the dispensary.[850] While Taylor also received the designation 'relieved', Duncan noted that 'from want of attend[ance] on [the] part of [the] patient' there had been 'no opport[unity] of judg[e]m[ent] of [the] effect[iveness]' of the treatment prescribed.[851]

Using this approach, the printed promotional material of the Edinburgh dispensary displayed positive outcomes in cases which otherwise may have reflected negatively on its medical practice. The Kelso dispensary, likewise, used no categories which would have served to indicate that an individual had chosen to stop receiving treatment (Figure 6.1). This implies that they, like the Edinburgh dispensary, were disguising the extent of their non-attendance figures within the data they published. The Newcastle reports, by contrast, in line with that dispensary's more rigorous approach to the collection of patient data, included the category of 'irregular' (Figure 6.2). This term, while its meaning is not clearly defined, seems likely to have been used to indicate those individuals who were irregular in the context of their attendance for treatment.[852] The percentage of irregular cases at the Newcastle dispensary was consistently low, always below 5 per cent. While equivalent statistical data is not available for the Edinburgh dispensary, the frequency with which Duncan noted that patients had abruptly ceased attending suggests that its numbers were significantly higher. This variation is likely to be due, in part, to the Newcastle dispensary's development of a structured approach to home visits.[853] For those institutions, as in the

[848] Duncan, *A General View of the Effects of the Dispensary at Edinburgh. During the First Year of that Charitable Establishment*, p.10; *Practical Observations in Medicine by Andrew Duncan*, 1777 (DEP/DUA/1/14), p.130.
[849] *Practical Observations in Medicine by Andrew Duncan*, 1778 (DEP/DUA/1/17), p.227.
[850] Ibid.
[851] Anon., *A General View of the Effects of the Dispensary at Edinburgh. During the Second Year of that Charitable Establishment*, p. 19; *Practical Observations in Medicine by Andrew Duncan*, 1778 (DEP/DUA/1/17), p.227.
[852] While the title of this category could also imply that the individual was irregular in the sense that they were falsifying their medical condition, the application of this term to conditions such as surgical cases, fever and, dropsy makes this unlikely. See Anon., *Newcastle Dispensary Annual Report* (1780), n.p.
[853] The variation in the use of home visits as part of dispensaries treatment techniques is discussed in more detail in chapter two of this thesis.

case of Edinburgh, that did not systematically carry out treatment in patients' homes, they were reliant primarily on the patient's active attendance at the dispensary both to continue treatment and to determine medical outcomes.

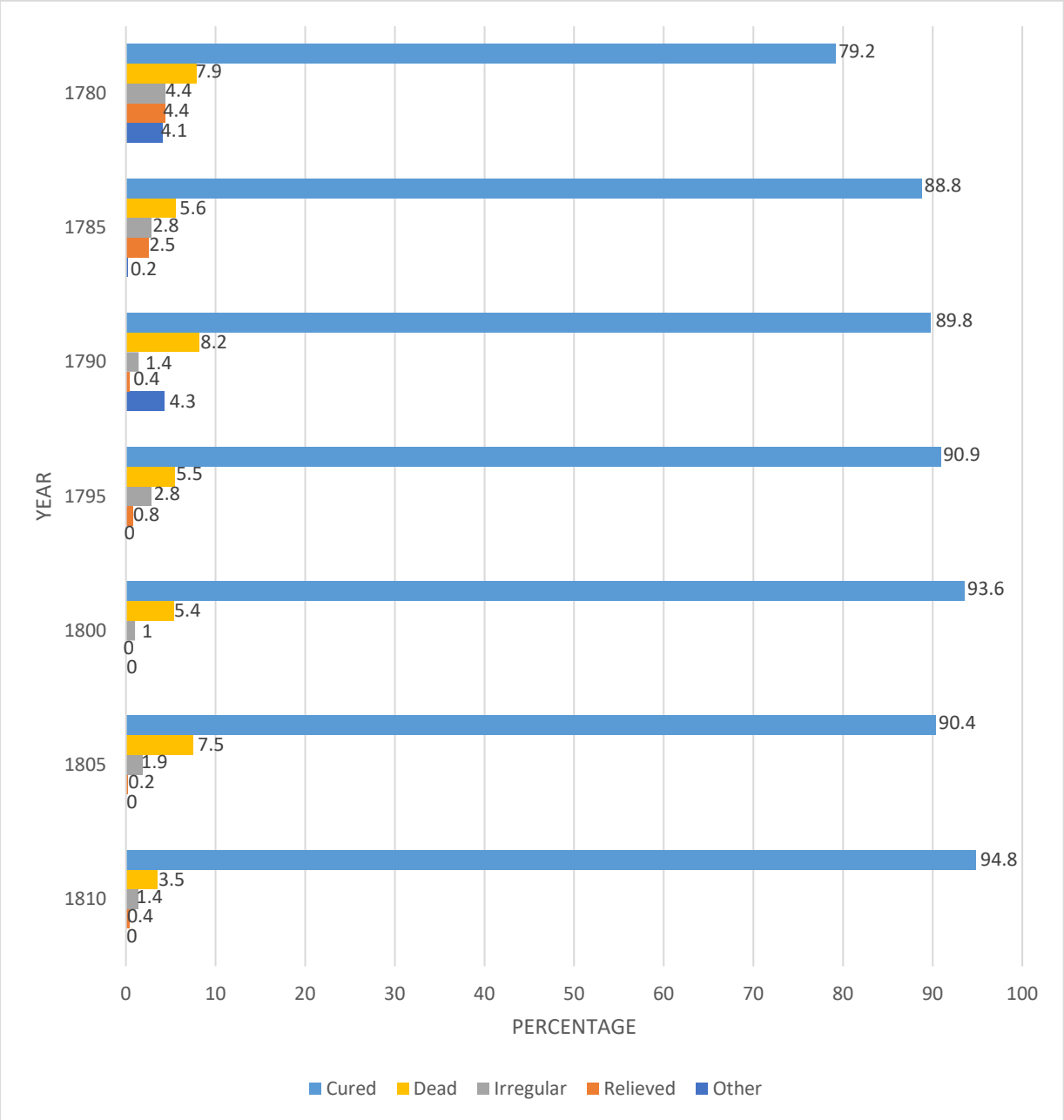
Figure 6.1. Disease outcomes at the Kelso dispensary, as a percentage of cases where outcomes were recorded, 1780-1805.[854]



Source: *Kelso Dispensary Patient Registers*, 1780-1805 (HH71/7-8 and HH71/43).

[854] The other outcomes detailed at the Kelso dispensary were not consistently applied, but rather used on an ad hoc basis. In 1780, one individual was 'sent to the country', one was 'dismissed', and one recorded as 'disease too far advanced'; in 1785 one individual was 'sent to infirmary' and one recorded as 'leg cut off'; in 1795 one individual was 'dismissed for contumacy' and in 1800 one individual was 'removed to Dundee'. *Kelso Dispensary Patient Registers*, 1780-1800 (HH71/7-8 and HH71/43).

Figure 6.2. Disease outcomes at the Newcastle dispensary, as a percentage of cases, 1780-1810.[855]



Source: Anon., *Newcastle Dispensary Annual Reports* (Newcastle, 1780-1810).

[855] The category of 'other' comprises: 'incurable', 'advised to the country', 'went to infirmary', and 'cases too far advanced'.

The Newcastle dispensary data, however, gives only a partial picture because, as noted in chapter two, patients who were admitted without a donor's recommendation were not included in the dispensary's printed statistics of medical outcomes.[856] These individuals regularly accounted for between a third and half of all patient admissions.[857] As this group was described as comprising 'casualties, and slight cases' it is likely that many of these cases were less severe, less likely to be fatal and, therefore, their non-inclusion in the overall totals may have skewed the outcomes displayed in figure 6.2.[858]

Figures 6.1 and 6.2 demonstrate a similar trend at both the Kelso and Newcastle dispensaries over the course of the late eighteenth, and into the nineteenth, century. This took the form of an increase in the percentage of patients recorded as cured and a decrease during the same period of the percentage who died while undergoing treatment. Although a slight variation can be seen at both dispensaries for the year 1805, an anomaly which will be considered in the following chapter in the context of specific economic and environmental factors, overall, both dispensaries experienced an increase in positive outcomes for their patients. The growing use of the dispensaries for less severe medical conditions such as stomach complaints and ulcers, alongside improvements in general population health are likely to have been significant factors in the improvement in health outcomes displayed in this data.[859]

6.5 Conclusion

This examination of treatments and medical outcomes has shown that, despite significant continuities during the late eighteenth and early nineteenth centuries, therapeutic methods did not remain entirely static. This is particularly the case when considering the development of charitable medical care, which inevitably impacted on treatment models. While medical treatments, in theory, may not have changed greatly, they were, by necessity, adapted to the circumstances of the individual institution. By the later eighteenth century infirmaries and dispensaries were admitting patients on a large scale and physicians

[856] Although the overall total of non-recommended cases was noted in the annual reports, unlike recommended cases they were not broken down by disease and their outcomes were always recorded as 'cured'. Anon., *Newcastle Dispensary Annual Reports* (1790-1810).
[857] Ibid.
[858] Ibid.
[859] The subject of improvements in general population health are discussed in more detail in chapter five.

who had previously treated individual private patients were now faced with wards and waiting rooms full of the sick poor. Approaches were adapted to accommodate this expansion in medical provision, while the limited funds available to such charities served to restrict the range of medicines which could be prescribed.

This analysis has demonstrated how prescriptions which were commonplace in the treatment of the wealthy, such as a focus on exercise and travel to warmer climates, played a significantly smaller role in the treatment of the sick poor. It has also illustrated that, while existing studies which have focused on infirmary patients have identified an emphasis on physical methods of treatment, such as bleeding, dispensaries, to a significant extent, developed their own distinctive methods of provision. The treatment of the sick under an outpatient system, combined with attempts by dispensary physicians to develop new treatment models, resulted in an emphasis on the prescription of medicines over physical methods of treatment. Determining the medical outcomes of such techniques is more difficult to discern, however, and while broadly outcomes appear to have improved, printed summaries of this information provide insight into the intentions of their authors as much as the wellbeing of their patients. The next chapter will consider this subject in more detail by uncovering the role of the dispensaries in the burgeoning public health movement, including attempts to engage with broader issues which impacted on the health of the populace such as sanitation, town planning, and living conditions.

Chapter 7. Public Health

Unwholesome air, heat, cold, smoke, humidity, damp houses, the effluvia of marshes, dung hills, human remains, slaughter houses, soap boiling, washing laundry in hard water, improperly boiled beef, drinking rain water and melted snow, the use of wooden pipes for conveying water, and contaminated bread and beer. The causes of disease cited by Andrew Duncan in the 1790s in a lecture series on public health were lengthy and wide ranging.[860] What is also clear from Duncan's assessment is how few of these causes were the result of the individual carrying out their day-to-day activities. They were predominantly broader issues: issues of sanitation, environment, and poverty.

While the subject of British public health has most often been studied by historians in the context of the sanitary reforms which took place during the second half of the nineteenth century, the earlier period has also been considered within the existing literature. The historian George Rosen, alongside René Sand, provided some of the earliest detailed studies of public health in the eighteenth century.[861] In their works this period of history was viewed, as Dorothy Porter has described it, in terms of 'grand narratives of progress'.[862] In essence, the perceived failure to take meaningful action in the eighteenth century was viewed as an unfortunate precursor to the public health developments which took place in the following century. Roy Porter subsequently debated this view of the pre-Victorian state of public health, arguing that many examples of undertakings by parish authorities, individuals, and charities to improve public health conditions in the earlier period can be identified.[863] While action at a governmental level to improve public health was limited prior to the developments of the later nineteenth century, historians have increasingly studied public health in the earlier period, not as it pertains to the undertakings

[860] *The Praelectiones of Andrew Duncan MD on the Theory of Medicine Delivered at Edinburgh in 1792-1793, Volume Two* (RCPE, DEP/ROA/2), n.p.
[861] George Rosen, *A History of Public Health* (New York, 1958); René Sand, *The Advance to Social Medicine* (London and New York, 1952).
[862] Dorothy Porter, *Health Citizenship: Essays in Social Medicine and Biomedical Politics* (Berkeley, 2011), p.10.
[863] Roy Porter, 'Cleaning up the Great Wen: Public Health in Eighteenth-Century London', in W. F. Bynum and Roy Porter (eds), *Living and Dying in London* (London, 1991), pp.61-75

of the state, but rather in the context of collective action more generally, even when restricted to local bodies or groups of individuals.[864]

This chapter does not consider public health initiatives adopted by civic authorities, parish bodies, or landowners during this period, the body of work within this field already being so extensive that it is not feasible to advance it here. Rather, the focus of this chapter will be on the roles of the Edinburgh, Kelso, and Newcastle dispensary staff in addressing public health concerns in the late eighteenth and early nineteenth centuries. It will begin by considering the local conditions which impacted on the health of the populace in each of the districts under consideration here, conditions of housing, water supply, and sanitation. It will then address the growing public health movement during this period, particularly in the context of the activities of dispensary physicians. Next, the analysis will turn to the activities of the Edinburgh, Kelso, and Newcastle dispensary staff within one particular component of public health provision – smallpox vaccination – before considering their undertakings in relation to epidemics and contagious diseases more broadly. In considering these subjects, this chapter will uncover the role of the dispensaries beyond the care of individuals who presented themselves for treatment and show how disease prevention, as well as treatment, was increasingly viewed by many dispensaries as a key component of their work.

7.1 The Origins of a Public Health Movement

The expansion of urban centres which took place over the course of the eighteenth century put increasing pressure on already inadequate housing, water supplies, and waste disposal facilities. The city of Newcastle was particularly affected by these developments. While accurate demographic statistics are lacking for the period under study, estimates suggest the population of the city had reached approximately 30,000 by 1770 due, in large part, to increasing economic migration to the district.[865] More significantly, the distribution of this population was notably uneven, with a single parish, All Saints, housing approximately 50 per cent of the city's total population.[866] Newcastle's growth during this period was largely restricted to within its medieval walls. While wealthy inhabitants had begun to move further

[864] Dorothy Porter, 'The History of Public Health: Current Themes and Approaches', *Hygiea Internationalis*, 1:1 (1999), pp.9-21.
[865] Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne', p.56.
[866] Frederick Morton Eden, *The State of the Poor: or, an History of the Labouring Classes of England, Volume Two* (London, 1797), p.550.

away from the city's industrial and maritime centre, newer migrants seeking work continued to settle predominantly close to the river.[867] Indeed, the overcrowding in this area of the city was so extreme that by 1801 All Saints had the highest number of inhabitants: nine persons, per home in Britain.[868]

The development of necessary amenities did not keep pace with these demographic changes. The city's water supply, although passing through the hands of various individuals, did not experience significant improvement until the mid-nineteenth century.[869] While attempts were made to improve the supply in 1797 by sinking a new shaft, water was still only available two days a week and frequently ran out before all those who were waiting had been supplied.[870] In Edinburgh, similarly, ineffective attempts were made to mitigate the deficiencies of that city's water supply towards the end of the eighteenth century. New rules were introduced by the Town Council in 1799 which regulated water distribution, including limiting the amount which could be taken into private residences and barring those collecting water from the city's wells from using vessels which could hold over 20 pints.[871] Shortages of water were not the only concern; water leaking from pipes and public wells created patches of stagnant water which, when combined with waste matter, could become feculent.[872] In combination with industrial and domestic refuse and the lack of effective sewage disposal this created significant hazards for local populations. While Kelso did not experience problems as pronounced as those in larger municipalities, Christopher Douglas noted, in his article in the *Statistical Account*, that 'attention had [not] been paid to cleaning the gutters of the streets, and to cleanliness in general. The greatest part of the town stands upon a level, it therefore requires particular attention, to prevent water and filth of every kind from stagnating'.[873]

The effect on local populations of significant food shortages during the late eighteenth and early nineteenth centuries further compounded these issues. The impact of

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[867] Henry Bourne, *The History of Newcastle Upon Tyne: or, The Ancient and Present State of that Town* (Newcastle, 1736), p.126.
[868] Anon., *Abstract of the Answers and Returns Made Pursuant to an Act, Passed in the Forty-First Year of His Majesty King George III* (London, 1801), p.271; P. J. Corfield, *The Impact of English Towns, 1700–1800* (Oxford, 1982), p.183.
[869] Robert William Rennison, *Water to Tyneside: A History of the Newcastle and Gateshead Water Company* (Gateshead, 1979), pp.1-65.
[870] Ibid., p.5.
[871] James Colston, *The Edinburgh and District Water Supply: A Historical Sketch* (Edinburgh, 1890), p.25.
[872] Sinclair, *The Statistical Account of Scotland, Volume Six*, p.600.
[873] Douglas, 'Parish of Kelso', pp.595-596.

harvest failures, particularly in 1782 to 1783, 1795 to 1796, and 1800 to 1801, was felt across all three districts. The consequences of these shortages, however, were not as dramatic as had been the case in the previous century, aided by factors such as the improved transportation of foodstuffs and the increasing mobility of the populace.[874] In addition, historians have argued that Newcastle was less impacted than other English cities because residents consumed a range of grains in their diet and were subsequently not as reliant on corn as their counterparts in the south of England.[875] However, a fall in real wages over the course of the eighteenth century, combined with the rising prices of grain and other foodstuffs, ensured that the impact on the populace was still significant.[876] Furthermore, the seasonal nature of employment, particularly in Kelso, which was reliant on harvest work, and Newcastle, dependent as it was on the coal trade, produced significant periods of dearth. In all three of the districts under consideration here civic action was taken during particularly difficult periods to provide subsidised, or free, food for the local poor.[877] Indeed, it has been estimated that in Edinburgh during the closing years of the eighteenth century approximately one eighth of the population were fed by such charitable means.[878]

The impact of these local conditions can be witnessed in the medical outcomes of dispensary patients. As mentioned in chapter five, mortality rates at both the Kelso and Newcastle dispensaries, which had been declining over the course of the late eighteenth century, show a sudden increase in the early nineteenth century. This change began at both dispensaries in 1801.[879] The perceived causes of this increase in mortality are made explicit in the Newcastle dispensary's annual report for that year, in which it is stated that the 'harvest, in 1800, was late; the grain and potatoes damaged; and therefore the food of the poor has not only been scanty, but afforded little nutriment.'[880] At the Newcastle dispensary

[874] M. W. Flinn, 'The Stabilisation of Mortality in Pre-industrial Western Europe', *Journal of European Economic History*, 3 (1974), pp.285-318.
[875] G. E. Mingay, *The Agrarian History of England and Wales. Volume Six, 1750-1850* (Cambridge, 1989), p.104; p.731.
[876] R. J. Morris, 'Voluntary Societies and British Urban Elites, 1780-1850: An Analysis', *The Historical Journal*, 26:1 (1983), pp. 99-100.
[877] Brotherston, *Observations on the Early Public Health Movement in Scotland*, p.8; *Kelso Heritors' Records*, 14 August 1795 (HHH, SBA/183, Box 5/1); Butler, 'Disease, Medicine and the Urban Poor in Newcastle-upon-Tyne, p.95.
[878] Thomas Ferguson, *The Dawn of Scottish Social Welfare, A Survey from Medieval Times to 1863* (Edinburgh, 1948), p.23.
[879] *Kelso Dispensary Patient Register*, 1801 (HH71/43); Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1801).
[880] Anon., *Newcastle Dispensary Annual Report* (1801), p.6.

this increased death rate was particularly due to cases of continued fever, identified by the dispensary as being typhus. In 1803, 21 per cent of deaths while under the care of the dispensary were due to this condition alone.[881] The term typhus, as applied by the dispensary, cannot be assumed to equate with modern epidemic typhus as, during this period, this classification was given to a range of febrile conditions.[882] In the late eighteenth and early nineteenth centuries it was a condition particularly associated with industrialised areas and high levels of typhus cases were also recorded at dispensaries in other large English cities, such as Liverpool.[883] Indeed, it was common across Europe during this period.[884] English dispensaries, including that at Newcastle, were particularly burdened with such cases because of the common policy of English infirmaries to exclude potentially infectious conditions.[885]

In the years following 1801 the Newcastle dispensary continued to emphasise the high levels of typhus, both in the general population and amongst its patients. In the dispensary's 1803 annual report it was stated that:

> The typhus, or continued fever… has still been very prevalent, and occasioned much misery and considerable mortality; and as the contagion of this disease is constantly preserved in some of the habitations of indigence, and is often even spontaneously generated in crowded and dirty rooms; it is to be feared that the lower orders of society must continue to suffer severely from the spreading of this distemper, till such time as adequate provision shall be made by public munificence, not only for removing the persons first attacked by the fever, at an early period, into well ventilated apartments; but also for purifying the cloathing [sic], furniture, and infected habitations of sick families, as soon as the disease shall be over.[886]

[881] Anon., *Newcastle Dispensary Annual Report* (1803), n.p. This calculation does not include the category of those admitted without recommendations which, as previously noted, is not broken down by medical category.
[882] For a contemporary discussion of the nature of late-eighteenth-century typhus, see James Wood, *Thoughts on the Effects of the Application and Abstraction of Stimuli on the Human Body; with a Particular View to Explain the Nature and Cure of Typhus* (London, 1793).
[883] James Currie, *Medical Reports, on the Effects of Water, Cold and Warm, as a Remedy in Fever, and Febrile Diseases; Whether Applied to the Surface of the Body, or Used as a Drink: With Observations on the Nature of Fever; and on the Effects of Opium, Alcohol, and Inanition* (Liverpool, 1797), pp.210-211.
[884] Harrison, *Disease and the Modern World*, pp.65-71.
[885] The exclusionary policies of English infirmaries, including those regarding infectious diseases, are discussed in greater detail in chapter one of this thesis.
[886] Anon., *Newcastle Dispensary Annual Report* (1803), p.6.

It was clearly no longer viewed as sufficient for dispensary annual reports to simply detail the medical condition of their patients. Their authors increasingly strove both to understand the causes of these complaints and to identify the steps which should be taken to address them.

7.2 Addressing Public Health

The surrounding environment of the patient had long been considered as a significant component in the treatment and prevention of disease. Most common within humoral theory was the idea that climate and fresh air were key in rebalancing the body's humors.[887] Towards the end of the eighteenth century these theories began to coalesce with broader public health concerns. Older humoral ideas, however, were not entirely replaced; rather they were adapted and incorporated into these newer theories.[888] The concept of 'miasma', first discussed in the Hippocratic Corpus in the fifth century BC and taken to mean that certain towns or districts were, by their very nature, detrimental to an individual's health due to their location and unhealthy air, began to be studied in the eighteenth century in the context of the prevalence of certain epidemic diseases, local sanitary conditions, and the forms of employment of residents.[889]

A cohort of doctors, predominantly trained in Edinburgh and often working in close contact with one another, led the development of theories on infection in the late eighteenth century.[890] This group included Duncan and Clark alongside many other individuals who were either the founders of, or worked within, charitable dispensaries. Indeed a number of historians, including George Rosen and Roy Porter, have posited that dispensaries played a significant role in the growing interest in public health which took place in Britain during this period.[891] According to this argument the active engagement of dispensary physicians with their communities, particularly through visiting their poorer

[887] For a more detailed discussion regarding the relationship between humoral theory and diet, climate and environment, see R. J. Hankinson, 'Humours and Humoural Theory', in Mark Jackson (ed.), *The Routledge History of Disease* (Abingdon and New York, 2017), pp.40-53.
[888] Caroline Hannaway, 'Environment and Miasma', in W. F. Bynum and Roy Porter (eds), *Companion Encyclopedia of the History of Medicin*e, *Volume One* (London and New York, 1997), pp.292-306.
[889] Ibid.
[890] The mutual support and correspondence between physicians during this period on the subjects of contagion and inoculation is discussed in more detail by Margaret DeLacy in *Contagionism Catches On: Medical Ideology in Britain, 1730-1800* (Cham, 2017), pp.165-185.
[891] Rosen, *A History of Public Health*, pp.147-150; Roy Porter, 'Cleaning up the Great Wen', pp.73-74.

patients in their own homes, increased their interest in studying the impact of overcrowding, cleanliness, and diet on the health of the population. The principles which these physicians established and promoted emphasised that infectious diseases were transmitted by means of contagion. This contagion, rather than being based on those earlier theories which had identified generic 'bad air' as the source of disease, instead entailed contact with specific diseased particles.[892] Exposure to infection, therefore, particularly in overcrowded and unsanitary environments, was identified as the key factor in the transmission of diseases such as typhus and smallpox. Emphasis began to be placed increasingly, not on the individual, but rather on their surrounding environment.

A growing interest in the health of the populace, variously termed 'public health', 'medical law, and 'medical police', can be witnessed across Europe during this period.[893] On the continent, particularly in France and Germany, these concepts became associated with state action and tended to take the form of increasing regulation of public works such as street sweeping, water supply, and waste disposal.[894] In eighteenth-century Britain, Andrew Duncan became the individual most closely associated with this burgeoning movement. This is due, primarily, to his pivotal role in the establishment of Britain's first academic course on public health which was based, in large part, on the developing continental model. Duncan was appointed as the Professor of the Theory of Physic at the University of Edinburgh in 1789 and shortly afterwards began to incorporate material on public health into his lectures.[895] He published his first work on this subject in 1792 and around the same time began the lengthy process of persuading the city's Town Council and the university's managers to establish the subject as a distinct discipline.[896] His endeavours finally came to

[892] Physicians who studied and wrote on the subject of contagion in this revised form included John Haygarth, physician at the Chester infirmary and James Currie, physician at the Liverpool infirmary. John Haygarth, *An Inquiry How to Prevent the Small-Pox. And Proceedings of a Society For Promoting General Inoculation at Stated Periods, and Preventing the Natural Small-Pox, in Chester* (Chester, 1784); Currie, *Medical Reports, on the Effects of Water, Cold and Warm, as a Remedy in Fever.*

[893] In some instances these terms have been used interchangeably. More commonly, the concept of medical law included public health elements, but also elements relating to criminal proceedings including homicide. For a more detailed discussion of this subject, see Paul Laxton and Richard Rodger, *Insanitary City: Henry Littlejohn and the Condition of Edinburgh* (Lancaster, 2013), pp.23-28.

[894] Klaus Bergdolt, *Wellbeing: A Cultural History of Healthy Living* (Cambridge and Malden, 2008), pp.247-250.

[895] *The Scots Magazine*, December 1789, p.624.

[896] Andrew Duncan, *Heads of Lectures on Medical Jurisprudence or the Institutiones Medicinae Legalis* (Edinburgh, 1792).

fruition in 1807, although this new position was not based within the medical faculty, but rather under the aegis of the faculty of law.[897]

Historians, including Brenda White, have argued that Duncan's approach to public health, as detailed in his university lectures, emphasised voluntary charitable activities over the intervention of civic authorities and, in White's words, Duncan's writing on the subject 'betrays no discontent with the existing traditional system of elementary sanitary provision'.[898] However, more detailed study of the lecture notes taken by Duncan's students demonstrates that his recommendations were significantly more wide ranging. These included descriptions of the actions which individuals could take to combat the transmission of infectious diseases, including the cleaning of homes and ensuring that clothing was regularly washed.[899] However, the onus was not placed entirely upon the individual; Duncan also emphasised the measures which he believed that civic authorities should take, such as improving sanitation, the regular fumigation of jails, replacing existing water pipes made from wood and lead with case iron ones, the drainage of marshy land, and ensuring that the slaughtering of animals took place outside urban areas.[900] Indeed, Duncan was so fervently in support of the latter proposition that he stated that the 'Magistrates of Edin[burgh] should all be induced to bear the duck in the South Sea, for their extreme negligence with respect to it'.[901] This bold statement by Duncan hardly tallies with White's suggestion that he felt no discontent with the existing actions of civic authorities.

Clark also emphasised the importance of public health measures in his printed works. He, like Duncan, argued that formal authorities must play a central role. One proposal by Clark, although never enacted, was the establishment of a Board of Health.[902] This was to be comprised of medical professionals and representatives from parish bodies

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[897] George Rosen, 'The Fate of the Concept of Medical Police 1780-1890', *Centaurus*, 5:2 (1957), p.108.
[898] Brenda M. White, 'Medical Police. Politics and Police: The Fate of John Roberton', *Medical History*, 27:4 (1983), p.409.
[899] *The Praelectiones of Andrew Duncan MD on the Theory of Medicine Delivered at Edinburgh in 1792-1793, Volume Two* (DEP/ROA/2), p.88.
[900] Ibid., pp.77-84.
[901] Ibid., p.80. Although we lack a clear definition of what ducking, in this context, entailed, mention of ducking is made in an eighteenth-century work by Amédée François Frézier. He describes the process as an initiation ritual amongst sailors, whereby they would be tied with ropes and then briefly lowered into the sea. Amédée François Frézier, *A Voyage to the South-Sea, and Along the Coasts of Chili and Peru, in the Years 1712, 1713, and 1714* (London, 1717), pp.14-15.
[902] Clark, *A Collection of Papers, Intended to Promote an Institution for the Cure and Prevention of Infectious Fevers in Newcastle and Other Populous Towns*, pp.12-17.

and was to be financed via poor relief funds.[903] Its responsibilities were to include ensuring that the homes of those infected were cleaned to prevent the spread of contagious diseases.[904] Clark also emphasised the significance of the forced proximity of the poor with those who were infectious. In the case of James Dryden, a mariner, aged 44, who was admitted into the Newcastle dispensary in October 1778, his fever manifested as a 'violent head-ach and thirst' and he was 'delirious… his spirits were dejected'.[905] Clark believed that Dryden had caught his fever from 'lying in the same room' with three of his children who had previously been infected.[906]

Clark also produced a pamphlet which was distributed to patients at the Newcastle dispensary which detailed the steps they should take to prevent and contain infection. This pamphlet, first published in 1791, emphasised personal and domestic cleanliness and ensuring the circulation of fresh air, giving advice such as to 'sweep your houses; open the windows'.[907] Readers were also advised to 'wash your children at least every morning' and to regularly change the bed linen of the sick.[908] Not all of these recommendations, however, received general public approval. The importance of cleanliness, for example, was met with only limited approbation. Folk traditions surrounding the treatment of the sick remained into the eighteenth century, including the idea that it was dangerous to the health of a sick person to wash them or change their bedding.[909] Notions such as these, however, were not the only inhibitors to following physicians' advice. Income was a further factor. John Pringle, for example, ensured that one of the fever patients he visited at their home was transferred to a spare bed during the period of their recovery.[910] In the case of another fever patient, an eight-year-old boy, Pringle described how he 'made a Servant, a young man, Strip, go into bed, and take him into his arms in order to give him heat'.[911] For the poor who did not

[903] Ibid.
[904] Ibid.
[905] Clark, *Observations on Fevers, Especially Those of the Continued Type*, pp.111-112.
[906] Ibid., p.111.
[907] The pamphlet was later reproduced in a separate publication by the dispensary. See Anon, *Proceedings of the Committee for Increasing the Usefulness of the Dispensary at Newcastle Upon Tyne* (Newcastle, 1802), pp.34-35.
[908] Ibid.
[909] Genevieve Miller, *The Adoption of Inoculation for Smallpox in England and France* (Philadelphia, 1957), p.39.
[910] *Medical Annotations by Sir John Pringle*, *Volume Eight*, c.1770 (DEP/PRJ/1/8), p.128.
[911] *Medical Annotations by Sir John Pringle*, *Volume One*, c.1778 (DEP/PRJ/1/1), pp.64-65.

possess spare beds or manservants who could be impelled to expose themselves to potential infection the options were considerably more limited.

Like Duncan, Clark's most significant efforts to address broader public health concerns took place outside the walls of the dispensary. In 1788, after a failed attempt the previous year, Clark finally succeeded in being elected as a physician to the Newcastle infirmary.[912] He subsequently undertook a systematic review of the work of that institution and in 1801 presented a report of his findings to the infirmary's governors.[913] In this report he made a range of recommendations. These included the need for improved cleanliness and ventilation on the wards.[914] He also emphasised the necessity of reviewing the infirmary's process for admitting patients, which Clark argued had resulted in the infirmary becoming more akin to an 'alms-house' for the incurable rather than an institution for treating the sick.[915] His tone in this report was strident, describing the management of the infirmary as 'in a complete state of disorganization'.[916]

The most significant recommendation of this report, however, was that fever wards be established as an adjunct to the infirmary.[917] The continuing insistence of the infirmary that no infectious cases be admitted was clearly at variance with the needs of the populace given the high rates of fever cases in the city during the early nineteenth century. In his proposals Clark detailed correspondence between himself and Duncan who, by that time, had regained access to the Edinburgh infirmary teaching wards as a result of his accession to a university professorship.[918] In his correspondence with Clark, Duncan emphasised that the establishment of fever wards at the Edinburgh infirmary had resulted in no cross contamination with neighbouring properties.[919] However, while many of Clark's more minor suggestions were adopted, his proposed fever wards were rejected by the infirmary's

[912] *Newcastle Courant*, 7 April 1787, p.2; *Newcastle Courant*, 3 May 1788, p.4.
[913] This report, initially published in 1801, was also summarised the following year in a publication by Clark which collected together a number of related comments, extracts from correspondence and illustrations of the proposed developments. Anon., *An Account of the Plan for the Internal Improvement and Extension of the Infirmary, at Newcastle* (Newcastle, 1801); Clark, *A Collection of Papers, Intended to Promote an Institution for the Cure and Prevention of Infectious Fevers in Newcastle and Other Populous Towns.*
[914] Clark, *A Collection of Papers, Intended to Promote an Institution for the Cure and Prevention of Infectious Fevers in Newcastle and Other Populous Towns*, p.8.
[915] Ibid., p.7.
[916] Ibid., pp.42-43.
[917] Ibid., p.5.
[918] Ibid., p.57.
[919] Ibid.

managers.[920] Clark's persistence, however, did result in a separate House of Recovery for fever patients being established in 1804 outside the city's walls.[921] The medicines and medical support for this new institution were supplied, not by the Newcastle infirmary, but rather by the city's dispensary.[922] This new undertaking appears not to have been a great success, with one contemporary stating, in 1811, that it was 'frequently empty' of patients.[923] Quite why it failed in this regard is not clear, but perhaps support for yet another medical institution in the city was limited in a period where funders had already begun to turn away from this model of charitable relief. Equally, the death of Clark in 1805, only one year after its establishment, may have left the charity somewhat adrift without the guiding hand of its champion.

The opposition of the infirmary to the establishment of these new fever wards, at least according to the statements of its medical staff, had been based primarily upon concerns that they would result in infection being spread amongst other patients.[924] Clark had countered these arguments by stating that such fears stemmed from outdated medical ideas which had originated in a period when the principles of contagion and disease prevention were not 'so well understood as at present'.[925] These ideas were based on the notion that diseases would not be transmitted through infected clothing, food, or water, but rather on the 'external air' as it moved between entirely separate buildings.[926] Contagionist theory, although increasingly adopted by medical practitioners during the late eighteenth century, was not uniformly accepted, as the Newcastle infirmary staff's pronouncements demonstrate. Many other physicians, including William Buchan, while not rejecting contagionist theory, combined elements of this approach with earlier theories of disease transmission. According to Buchan, while infectious diseases were spread partially by dirty living conditions and close proximity to the infected, they could also be brought about by

[920] Ibid., pp.5-16.
[921] Miller, 'Dr John Clark: The Forgotten Physician, 1744-1805', p. 131.
[922] Ibid., p.132.
[923] *Mackenzie, A Historical and Descriptive View of the County of Northumberland, and of the Town and County of Newcastle Upo*n Tyne, Volume Two, pp.747-748.
[924] Clark, *A Collection of Papers, Intended to Promote an Institution for the Cure and Prevention of Infectious Fevers in Newcastle and Other Populous Towns*, pp.20-22.
[925] Ibid., p.21.
[926] Ibid., p.22.

eating cherries, drinking strong liquor, and having excessive 'passions or affections of the mind'.[927]

Advocates of the new contagionist theory, including Clark, began to counter these claims by carrying out statistical studies which examined the spread of diseases, the usefulness of various treatments, and patient mortality rates.[928] Ulrich Tröhler has characterised this move from an earlier focus on individual case histories to the study of large data banks of information as a burgeoning 'numerical culture' of disease analysis.[929] There is some debate amongst historians as to the practical impact of this increased focus on contagion in the late eighteenth and early nineteenth centuries. Mark Harrison has emphasised that, while eighteenth-century physicians increasingly wrote on the subject of contagion, significant public health measures such as improving sanitation were only widely adopted around a century later.[930] However, the historian Alex Mercer has argued that these developments were significant, not because of their immediate impact on public health, but rather in establishing principles of disease prevention, moving away from the earlier focus on simply curing disease.[931] This change in the mindset of physicians, according to Mercer, led directly to the civic initiatives which were undertaken in the later nineteenth century.[932]

According to the historian Margaret DeLacy, this focus on contagion as the primary method of transmission of infectious diseases also led to an increased emphasis on diseases as separate entities.[933] Christopher Hamlin, similarly, has described how fever, once viewed as a single disease, became pluralised as many separate febrile diseases with distinct causes and characteristics began to be isolated.[934] DeLacy has argued that this development from the more general ideas of infectious disease to specific individual diseases began with smallpox.[935] This disease proved a model for the burgeoning interest in public health

[927] Buchan, *Domestic Medicine,* p.108; p.144.
[928] Ulrich Tröhler, 'The Introduction of Numerical Methods to Assess the Effects of Medical Interventions During the 18th Century: A Brief History', *Journal of the Royal Society of Medicine*, 104:11 (2011), pp.465-474.
[929] Ibid., pp.469-470.
[930] Harrison, *Disease and the Modern World*, p.61.
[931] Alexander Mercer, *Infections, Chronic Disease, and the Epidemiological Transition: A New Perspective* (Rochester, 2014), pp.15-16.
[932] Ibid.
[933] Margaret DeLacy, 'Influenza Research and the Medical Profession in Eighteenth-Century Britain', *Albion: A Quarterly Journal Concerned with British Studies*, 25:1 (1993), p.51.
[934] Christopher Hamlin, *More Than Hot: A Short History of Fever* (Baltimore, 2014), p.165.
[935] DeLacy, 'Influenza Research and the Medical Profession in Eighteenth-Century Britain', pp.50-52.

because of one distinctive characteristic. Smallpox was the only eighteenth-century infectious disease which could be prevented by a single act, the process of inoculation.

7.3 Inoculation and Vaccination

Smallpox inoculation was adopted formally by medical authorities in Britain in the first half of the eighteenth century after it was promoted by high profile individuals such as Sir Hans Sloane, the king's physician.[936] Some historiographical studies, however, including that of Charles Creighton, have noted that inoculation was already being undertaken prior to this development.[937] In rural areas, such as the highlands of Scotland, the procedure had been carried out by folk healers long before it was sanctioned by prominent members of the political and medical elite. Indeed, even after the mid-eighteenth century this procedure remained, in the eyes of many, a folk rather than orthodox medical procedure. In many rural areas individuals such as blacksmiths and church ministers, rather than physicians, continued to be responsible for carrying out the procedure within their communities.[938]

Inoculation, however, remained a controversial procedure. There was considerable public fear that it would not prevent smallpox outbreaks, but rather cause them as it involved infecting an individual with a supposedly mild dose of the disease in order to induce natural immunity. Particular concern was voiced, including by physicians who otherwise supported inoculation, regarding the adoption of the procedure in large towns and cities.[939] The impossibility, in such instances, of simultaneously inoculating the majority of residents led to fears that undertaking this procedure would serve to spread contagion. While the death rate which resulted from inoculation was significantly lower than deaths from naturally contracted smallpox, even a small number of fatalities could exacerbate public fears. In order to counter these concerns, some physicians presented detailed statistical evidence to demonstrate the greater survival rates of those who were inoculated.[940] In addition, contemporary writers, including William Buchan and Hugo Arnot,

[936] Ian Glynn, Ian and Jennifer Glynn, *The Life and Death of Smallpox* (New York, 2004), pp.55-94.
[937] Creighton, *A History of Epidemics in Britain, Volume Two*, p.471.
[938] David Hamilton, *The Healers: A History of Medicine in Scotland*, p.96.
[939] Thomas Dimsdale, *Thoughts on General and Partial Inoculations* (London, 1776), pp.20-27.
[940] Andrea Rusnock, ' "The Merchant's Logick": Numerical Debates over Smallpox Inoculation in Eighteenth-Century England', in Eileen Magnello and Anne Hardy (eds), *The Road to Medical Statistics* (Amsterdam and New York, 2002), pp.37-51.

emphasised the role of church ministers in educating their parishioners regarding the importance of inoculation.[941] According to Arnot, this 'remedy [is] so compleat, that we hesitate not in the least to pronounce those parents, who will not inoculate their children for the small-pox, accessory to their death'.[942]

Alongside these concerns the poor faced an additional obstacle: the high cost of inoculation. The method adopted by medical practitioners in the first half of the eighteenth century was convoluted and expensive, involving weeks of preparation, bleeding, purging, and a restricted, or 'low', diet.[943] This was followed by the creation of a deep incision in order to insert smallpox scabs or fluid, a process which required a lengthy period to heal. This approach had its origins in humoral theory, whereby the body's humors needed to be rebalanced prior to inoculation. During the 1750s and 1760s an English surgeon, Robert Sutton, developed a simpler process which involved a more superficial cut and therefore required less recovery time.[944] After the process was publicised by his son, Daniel Sutton, it was widely adopted by medical practitioners.[945] Although the Sutton method reduced the expense of the procedure, this new approach still necessitated the taking of a range of medicines and a special preparatory diet and so remained out of the reach of many poorer members of society.[946]

The provision of free inoculation by charitable bodies, therefore, made the procedure more widely available. In some English parishes inoculation was funded via poor relief, particularly in the south and south east of England.[947] There is no evidence, however, that this was the case in Edinburgh, Kelso, or Newcastle. Nor were there specific institutions for inoculation established in these districts during the eighteenth century, as was the case in London.[948] In addition, unlike the infirmaries in certain English cities such as Manchester,

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[941] Buchan, *Domestic Medicine*, p.161; Arnot, *The History of Edinburgh*, p.260.
[942] Arnot, *The History of Edinburgh*, p.260.
[943] James Burges, *An Account of the Preparation and Management Necessary to Inoculation* (London, 1754), pp.19-22; Andrea A. Rusnock, *Vital Accounts: Quantifying Health and Population in Eighteenth-Century England and France* (Cambridge and New York, 2002), p.92.
[944] Ibid.
[945] Ibid.
[946] Michael Bennett, 'Inoculation of the Poor against Smallpox in Eighteenth-Century England', in Anne M. Scott (ed.), *Experiences of Poverty in Late Medieval and Early Modern England and France* (Farnham and Burlington, 2012), pp.207-208.
[947] Deborah Brunton, 'Pox Britannica: Smallpox Inoculation in Britain, 1721-1830' (Ph.D. diss., University of Pennsylvania, 1990), p.148.
[948] Matthew L. Newsom Kerr, *Contagion, Isolation, and Biopolitics in Victorian London* (Cham, 2018), p.132.

neither the Newcastle nor Edinburgh infirmaries made this procedure available to their patients.[949] The only public body, other than the dispensaries, which appears to have filled this gap in provision was the Royal College of Physicians of Edinburgh. After a lengthy debate, lasting two decades, as to the virtues of providing public inoculation, the college advertised a free inoculation service in the printed press in 1791. However, only two advertisements have been found, from 1791 and the following year, and there is no indication as to the scale of the uptake of this offer.[950]

The Newcastle dispensary, by contrast, placed itself at the forefront of medical innovation in this field. Following the model developed by physicians elsewhere, including John Coakley Lettsom in London and John Haygarth in Chester, the dispensary offered free inoculations to infants and children in their own homes. This method was developed to avoid the possibility of spreading contagion by encouraging the inoculated to stay indoors. Indeed, the Newcastle dispensary carried their provision even further by offering mass inoculations twice a year, every year.[951] This contrasts with the inoculation programmes in other districts which were commonly rather sporadic and often only adopted at the height of epidemic outbreaks.[952] In addition, the Newcastle dispensary offered payments to the parents of inoculated children, thereby combating one of the major deterrents, the loss of earnings incurred by the need to care for children as they recovered.[953] Creighton described this provision as 'perhaps the most systematic attempt at infant inoculation' in Britain.[954]

The Newcastle dispensary had emphasised the importance of inoculation from its foundation.[955] A lack of sufficient funds, however, had prevented the immediate adoption of their proposed scheme. It was only in 1786, therefore, that their inoculation programme began in earnest. An anonymous pamphlet, almost certainly written by Clark, published in 1786, detailed the approach which was adopted.[956] It also served as a method of promotion and fundraising for the scheme. A call to the purses of the wealthy, it emphasised the benefits to the elite as well as the poor of the adoption of large-scale inoculation. This

[949] Brockbank, *Portrait of a Hospital, 1752-1948*, p.28.
[950] Deborah Brunton, 'Smallpox Inoculation and Demographic Trends in Eighteenth-Century Scotland', *Medical History*, 36:4 (1992), p.413.
[951] Anon., *An Account of the Newcastle Dispensary, for the Relief of the Poor*, p.6.
[952] Brunton, 'Pox Britannica: Smallpox Inoculation in Britain, pp.31-32.
[953] Anon, *Proposals for Promoting General Inoculation in Newcastle* (Newcastle, 1786), pp.7-8.
[954] Creighton, *A History of Epidemics in Britain, Volume Two*, p.508.
[955] Anon, *Newcastle Dispensary Annual Report* (1778), pp.25-29.
[956] Anon, *Proposals for Promoting General Inoculation in Newcastle*.

involved detailing the potential health implications for smallpox survivors, including blindness, lameness, and consumptions.[957] They would thereby be rendered 'a burden to their relations, and useless members of society'.[958] The impact of the disease was therefore not just sickness and death; it also included a depletion of poor relief funds.

Indeed, while smallpox inoculation does not appear in the parish relief records of Edinburgh, Kelso, and Newcastle, financial support for those who had contracted smallpox does.[959] In addition, while it is not possible to determine which of the blind, lame or otherwise debilitated individuals who received relief funds had been affected by the disease, it is likely that some were. Overall, however, identifying the impact of smallpox in the districts in question is difficult as detailed records do not exist. In Newcastle the bills of mortality in the late eighteenth century did not record causes of death. Similarly, the Edinburgh bills only recorded burials in certain churchyards, so totals for the entire city are not available.[960] Contemporary estimates, however, stated that approximately 10 per cent of all deaths in Edinburgh were caused by smallpox and around 15 per cent in Newcastle.[961]

While the Newcastle dispensary is the most prominent of the institutions under study here in the context of the provision of inoculation, evidence exists to demonstrate that the Edinburgh and Kelso dispensaries also offered this service. In an article in *The Scots Magazine* from 1781 it was noted that the 'children of indigent parents' would receive free inoculation at the Edinburgh dispensary as well as 'such medicines and attendance as may be thought necessary'.[962] Unfortunately no further mention is made of this provision in the dispensary records so it is not possible to determine how many inoculations were, at this time, carried out. Kelso, similarly, provided a free inoculation service to children in the town and surrounding districts. As with the Edinburgh dispensary, however, this service was not widely publicised. It was not mentioned in the dispensary's printed annual reports, with the

[957] Ibid., p.iii.
[958] Ibid.
[959] *Edinburgh Charity Workhouse Cashbook,* 23 July 1798 (SL146/6/4); *Kelso Parish Treasurer's Accounts*, 3 February 1787 (CH2/1173/43); *All Saints Parish Monthly Accounts*, 20 October 1786 (465/21).
[960] For a more detailed discussion of the deficiencies of the Newcastle bills of mortality, see Graham Butler, 'Yet Another Inquiry into the Trustworthiness of Eighteenth-Century Bills of Mortality: The Newcastle and Gateshead Bills, 1736-1840', *Local Population Studies*, 92 (2014), pp.58-72. Similar issues were detailed almost two centuries earlier in relation to Edinburgh's bills of mortality. See Sinclair, *Analysis of the Statistical Account, Volume One*, pp.188-194.
[961] Alexander Monro, *An Account of the Inoculation of Small Pox in Scotland* (Edinburgh, 1765), p.12; Anon, *Proposals for Promoting General Inoculation in Newcastle*, pp.10-11.
[962] *The Scots Magazine*, 1 January 1781, p.3.

only evidence of this practice residing in the handwritten patient registers. This may explain why the historian Deborah Brunton has asserted that 'there are no records of inoculation at the Kelso Dispensary'.[963] In practice, inoculations were performed regularly at the dispensary, the first recorded example having taken place in January 1780.[964] The Kelso dispensary then moved from providing inoculations to performing cowpox vaccinations in April 1805.[965]

Vaccination, like inoculation, had been practiced as a folk remedy long before it was adopted by orthodox medical practitioners.[966] This procedure, unlike inoculation, did not involve infecting the individual with smallpox. Rather, it comprised a naturally occurring vaccine, cowpox, which was administered to the patient by cutting their skin, using much the same method as had previously been undertaken with inoculation. The publication, in 1798, by the English physician Edward Jenner of the findings of his research on vaccination brought widespread acceptance of the viability and safety of this method.[967] The Newcastle dispensary was one of the earliest institutions to move from inoculation to vaccination, in 1801. The popularity of this procedure, by comparison to inoculation, is clear from the dispensary's statistics. While inoculation was carried out by dispensary staff 3268 times between 1786 and 1801, between 1801 and 1825 they vaccinated over 20,000 patients.[968] The Edinburgh dispensary appears to have experienced a similar increase in uptake as a result of their adoption of vaccination. In the same year that the Newcastle dispensary began to undertake this procedure, the Edinburgh dispensary established a 'vaccine institute' and began not only to vaccinate poor children gratis but also to supply samples to medical practitioners so they could undertake vaccination within their own districts.[969] Between February 1806 and February 1807 the vaccine institute carried out 1763 vaccinations.[970]

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[963] Brunton, 'Pox Britannica: Smallpox Inoculation in Britain', p.167.
[964] *Kelso Dispensary Patient Register*, 30 January 1780 (HH71/7).
[965] *Kelso Dispensary Patient Register*, 5 April 1805 (HH71/43).
[966] Watts, *Epidemics and History*, p.116.
[967] Edward Jenner, *An Inquiry Into the Causes and Effects of the Variolae Vaccinae, A Disease Discovered in Some of the Western Counties of England, Particularly Gloucestershire, and Known by the Name of the Cow Pox* (London, 1798).
[968] Creighton, *A History of Epidemics in Britain, Volume Two*, p.582.
[969] *Caledonian Mercury*, 5 August 1801, p.3; *Caledonian Mercury*, 27 May 1803, p.3.
[970] *Caledonian Mercury*, 14 February 1807, p.3.

7.4 Infection and Contagion

The ability to identify and potentially prevent smallpox was an anomaly in eighteenth- and early-nineteenth-century disease diagnosis. Other diseases, particularly the nebulous category of 'fevers', proved far more complex. In much the same way as with diseases such as cholera and colic, there are significant variations apparent between medical practitioners in both terminology and treatments of febrile complaints.[971] The most influential mid-eighteenth-century study of disease classification, that of the French physician Sauvages, identified fevers based on their symptoms, not their causes. According to Sauvages's analysis, fevers were divided into the categories of intermittent, remittent, and continued.[972] Intermittents were further subdivided into quotidian, tertian, and quartian, depending upon how often their symptoms recurred.[973] Although Sauvages classified these subdivisions as separate conditions, both Clark and Duncan, most likely influenced by the writings of Cullen, argued that these were separate stages of a single disease.[974]

Duncan's understanding of intermittent fever is exemplified by the case of Daniel Frazer, a sailor who was admitted into the Edinburgh dispensary's care in the summer of 1784.[975] This patient was identified as having become infected while overseas in Jamaica.[976] He had many of the hallmark symptoms of this disease including cold chills, high fever, sweating, and diarrhoea.[977] It was noted by Duncan that Frazer's condition had already passed through all the distinct stages of this disease (quartian, tertian, and quotidian) by the time of his admission to the dispensary.[978] Cases of intermittent fever contracted in tropical and more boggy regions such as Jamaica were viewed as being more likely to display all three stages of the condition.[979] However, if a patient was infected with a milder strain, as was usual with cases contracted locally, they often experienced only the tertian stage of the illness.[980]

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[971] The subjects of cholera and colic are discussed in more detail in chapter five.
[972] DeLacy, *Contagionism Catches On: Medical Ideology in Britain,* pp.138-140.
[973] Ibid.
[974] Clark, *Observations on Fevers, Especially Those of the Continued Type*, p.11; Allen Cameron, *Practical Observations in Medicine by Andrew Duncan*, 1778 (DEP/DUA/1/17), pp.157-178.
[975] Daniel Frazer, *Practical Observations in Medicine by Andrew Duncan*, 1783-1784 (DEP/DUA/1/33), pp.59-83.
[976] Ibid., p.60.
[977] Ibid., p.59.
[978] Ibid., pp.60-61.
[979] Mary Dobson, '"Marsh Fever"—The Geography of Malaria in England', *Journal of Historical Geography*, 6:4 (1980), pp.372-375.
[980] Ibid.

Visiting marshy or boggy areas was widely, although not unanimously, accepted during the eighteenth century as the primary factor in the contraction of intermittent fever.[981] This observation was the source of the term 'marsh fever' which, alongside 'ague', acted as interchangeable and more colloquial terms for intermittent fever.[982] As a result, in part, of this association with exposure to marshy land, historians have often equated intermittent fever with modern-day malaria.[983] However, it is likely that this classification, as well as including malarial cases, also included some instances of influenza and typhus.[984] It may even have included cases of rheumatism, a condition which, according to eighteenth-century physicians, shared many symptoms with intermittent fever.[985]

The role of mosquitoes in the transmission of malaria was not identified until the final decades of the nineteenth century.[986] In the eighteenth century, therefore, other causal factors were necessary to explain the relationship between marshland and the spread of intermittent fever. Contemporary medical understanding demonstrates the complexity of the relationship between contagionist theory and the earlier Hippocratic notions of 'bad air'. In the case of intermittent fever, which was understood not to be transmittable between individuals, contagionist theories were difficult to apply. Instead Duncan, like many of his contemporaries, argued that marshy grounds 'emit[tted] vap[ours]' which 'prom[oted] putrefac[tion]' of the marsh contents, thereby creating an unhealthy miasma in the surrounding environment.[987] This theory was notably similar to pre-contagionist understandings of disease causation.

While the significance of a person's proximity to marshland was widely acknowledged, other potential causes of intermittent fever were also considered by medical

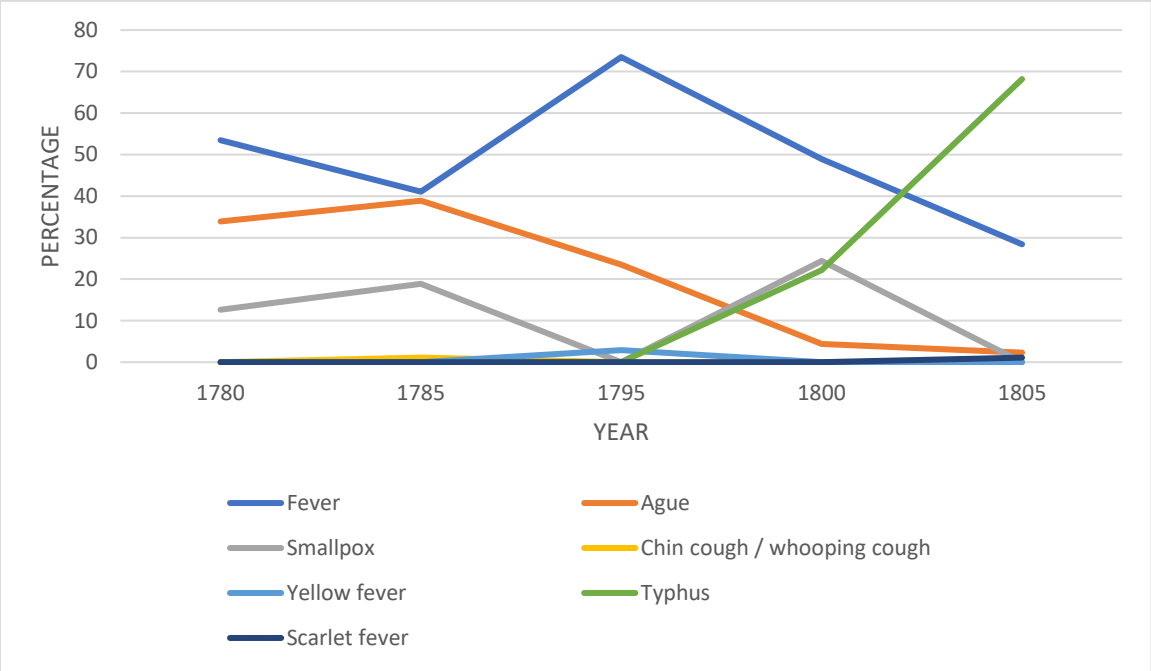
[981] For a more detailed discussion of eighteenth-century medical interpretations of the relationship between marshland and intermittent fever, see Mary J. Dobson, *Contours of Death and Disease in Early Modern England* (Cambridge, 1997), pp.287-367.
[982] Dobson, '"Marsh Fever" – The Geography of Malaria in England', p.364.
[983] Risse, 'Hospital History: New Sources and Methods', p.183; Randall M. Packard, *The Making of a Tropical Disease: A Short History of Malaria* (Baltimore, 2007).
[984] For a more detailed discussion of similarities between these complaints, see Creighton, *A History of Epidemics in Britain, Volume Two*, p.154 and pp.362-363.
[985] Duncan discussed the difficulty of distinguishing between these diagnoses on multiple occasions. See, for example, Alexander Henry, *Practical Observations in Medicine by Andrew Duncan*, November 1785 (DEP/DUA/1/38), pp.230-240.
[986] Leonard G. Wilson, 'Fevers', in W. F. Bynum and Roy Porter (eds), *Companion Encyclopedia of the History of Medicin*e, *Volume One* (London and New York, 1997), p.406.
[987] Cornelius Pringle, *Practical Observations in Medicine by Andrew Duncan*, 1782 (DEP/DUA/1/29), pp.230-240.

practitioners of the period, including an individual's diet, habitation, and the prevailing wind direction in the region in which they lived.[988] Indeed, as previously noted in writings of Buchan, in certain instances the causes of intermittent fever were argued to be emotional rather than environmental. In one example from the Edinburgh dispensary dating from the summer of 1780, a patient, John Hamilton, was admitted with a case of ague which was apparently induced by extremes of emotion.[989] Hamilton described himself as living in fear of catching a venereal complaint because he shared his home with an individual who had the disease.[990] This fear was, apparently, the cause of his intermittent fever. Duncan, although not entirely convinced by this theory, did note that it was 'true that appreh[ension] of danger has been observ[e]d to render [the] influ[ence] of other causes of disease, more powerful [in] febrile diseases of diff[erent] kinds'.[991] Disease, indeed, was 'often [the] conseq[uence] of passions of [the] mind partic[ularly] fear'.[992] Although Duncan had not witnessed a similar case in the past, he did not dismiss the possibility that fear had brought about this patient's case of intermittent fever.[993]

The Kelso dispensary is an oft-cited example in historiographical studies of intermittent fever outbreaks in eighteenth-century Britain.[994] This is primarily the result of the publication in 1842 of a work by Charles Wilson, covered in the introduction to this thesis.[995] Wilson identified a sharp decline in instances of this condition following a peak in the 1780s, a pattern which has also been replicated by analysis of the dispensary patient registers (Figure 7.1).[996]

[988] Buchan, *Domestic Medicine*, p.102; *Medical Annotations by Sir John Pringle*, *Volume Six*, c.1767 (DEP/PRJ/1/6), p.65; Douglas, 'Parish of Kelso', pp.593-594.
[989] John Hamilton, *Practical Observations in Medicine by Andrew Duncan*, 1780 (DEP/DUA/1/26), pp.152-156.
[990] Ibid., p.153.
[991] Ibid., p.154.
[992] Ibid., p.153.
[993] Ibid., pp.152-156.
[994] Creighton, *A History of Epidemics in Britain, Volume Two,* pp.369-370; Risse, *New Medical Challenges during the Scottish Enlightenment*, pp.180-181; Brotherston, *Observations on the Early Public Health Movement in Scotland*, pp.26-28.
[995] Charles Wilson, 'Statistical Observations on the Health of the Labouring Population of the District of Kelso', pp.317-355.
[996] Ibid., pp.328-329.

Figure 7.1. Breakdown of cases of infectious and epidemic diseases at the Kelso dispensary, as a percentage of total of infectious and epidemic diseases, 1780-1805.



Source: Anon., *Kelso Dispensary Annual Reports* (Berwick, Kelso, and Edinburgh, 1780-1805).

Intermittent fever was unusual among eighteenth-century epidemic diseases for its being primarily associated not with cities and other heavily populated districts, but rather with rural agrarian societies. Kelso and its surrounding area, although developing an increasingly complex labour market during this period, particularly in the context of weaving and related trades, remained reliant on farm work to fuel the local economy.[997] The land around Kelso, much of which was marshy, was central to employment and trade. Subsequently, the draining of this marshland in the late eighteenth and early nineteenth centuries was almost certainly the key factor in the corresponding decline of ague cases at the Kelso dispensary.[998]

By contrast, surviving data suggests that Edinburgh never suffered from intermittent fever outbreaks on a scale equivalent to those which took place in Kelso. Although Risse has identified peaks of this condition at the Edinburgh infirmary which broadly correspond with the timeline of those of the Kelso dispensary, they comprised a much smaller proportion of

[997] Henry Hamilton, *An Economic History of Scotland in the Eighteenth Century*, pp.158-159; Michael Robson, 'The Border Farm Worker', in T. M. Devine (ed.), *Farm Servants and Labour in Lowland Scotland, 1770-1914* (Edinburgh, 1984), pp.71-91.
[998] Charles Wilson, 'Statistical Observations on the Health of the Labouring Population of the District of Kelso', p.320.

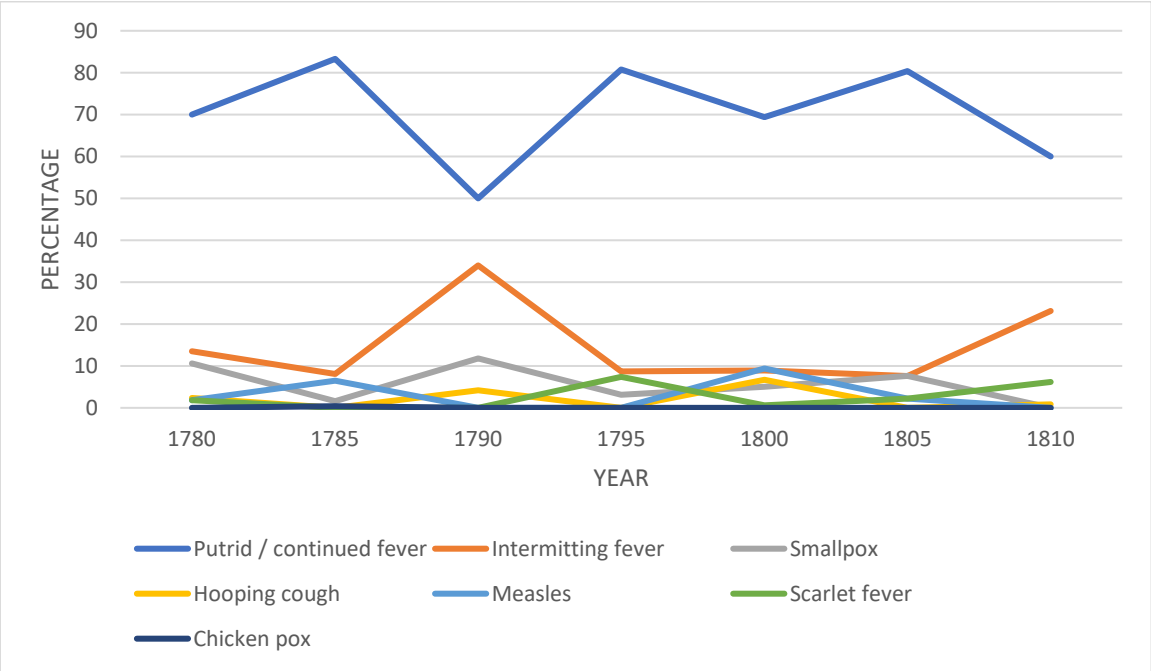
all patient admissions, around 3 per cent at the infirmary by contrast to Kelso's approximately 13 per cent.[999] In instances where the disease was identified at Edinburgh's infirmary and dispensary, it appears to have primarily been contracted by migrant workers while they were travelling outside the district. Risse notes that many of the admissions of this disease to the infirmary were highlanders who had recently returned from the south east of England, bringing the disease with them.[1000] Similarly, almost all the patients who were admitted to the Edinburgh dispensary with this condition were reported to have contracted it while carrying out harvest work in the 'fenny', or boggy, counties of England, including Norfolk, Cambridgeshire, and Kent.[1001] According to Duncan, the preponderance of this disease among such a specific demographic of the population created additional complexities in diagnosis and treatment. In the case of one sufferer, Archibald McDonald, it was noted that because 'our patient [is] a highlander' he could neither 'underst[and] quest[ions] nor give intellig[ent] answ[ers]'.[1002]

Improvement in drainage systems and the subsequent decline in rates of ague in southern England and in the Scottish borders was likely, therefore, to have been a significant factor in the reduction of intermittent fever cases in Edinburgh. Additionally, historians, including Mary Dobson, have also considered the possibility that a change took place in the virulence of the malarial parasite over the course of the late eighteenth and early nineteenth centuries, although there is insufficient evidence to corroborate this theory.[1003] Developed immunity may also have assisted in reducing the impact of outbreaks of intermittent fever. Individuals who were regularly exposed to the same strain of the disease, particularly in rural areas such as Kelso, could become partially inured to its effects over time.[1004] Bustling cities, however, which were filled with many transient individuals suffered from the regular introduction of new waves of the infected. Once again, Newcastle's role as a busy port left it open to the spread of disease as new strains were regularly introduced from overseas via the city's harbours. In that city, as was the case with

[999] Risse, *Hospital Life in Enlightenment Scotland,* p.135.
[1000] Ibid., p.134.
[1001] See, for example, Barbara Dun, *Practical Observations in Medicine by Andrew Duncan*, December 1788 (DEP/DUA/1/45), pp.119-121; John McDougall, October 1784 (DEP/DUA/1/36), pp.88-90; Francis Cruikshank, 1782-1783 (DEP/DUA/1/36), pp.80-99.
[1002] Archibald McDonald, *Practical Observations in Medicine by Andrew Duncan*, February 1786 (DEP/DUA/1/39), p.361.
[1003] Dobson, *Contours of Death and Disease in Early Modern England*, p.356.
[1004] Ibid., pp.359-360.

Edinburgh, those suffering from the disease were often identified as having contracted it further afield.[1005]

Figure 7.2. Breakdown of cases of infectious and epidemic diseases at the Newcastle dispensary, as a percentage of total of infectious and epidemic diseases, 1780-1810.[1006]



Anon., *Newcastle Dispensary Annual Reports* (Newcastle, 1780-1810).

The introduction of infection from overseas may explain why the peak of intermittent fever at Newcastle's dispensary does not correspond with the pattern already observed in relation to its counterparts in Edinburgh and Kelso. In this case the highest frequency of the disease, totalling 34 per cent of all infectious diseases, occurred later, in 1790 (Figure 7.2). Clark, in his published writing, noted additional complexities inherent in the treatment of intermittent fever cases. According to Clark, patients would frequently only come forward for treatment after months had passed and the disease had advanced to a more critical stage.[1007] In addition, he observed that sufferers of this condition 'consisted generally of the laborious poor' who, as a consequence of the 'narrowness of their

[1005] Clark, *Observations on the Diseases Which Prevail in Long Voyages to Hot Countries, Volume Two*, pp.304-305.
[1006] The 'putrid/continued fever' category was titled 'putrid fever' from 1778 until 1790. In 1791 and 1792 it was titled 'putrid contagious fever' and then from 1793 to 1810 it was titled 'continued fever'. In the year 1780 the category of scarlet fever was combined with cases of 'ulcerated sore throat'.
[1007] Clark, *Observations on the Diseases Which Prevail in Long Voyages to Hot Countries, Volume Two*, pp.304-305.

circumstances, as well as from prejudice', did not continue their medical treatment for a sufficient amount of time for it to take effect.[1008] Clark was not the only practitioner to observe a class-related element to the contraction of intermittent fever. As knowledge of the source of the infection became more widely known, increasingly the wealthy moved away from contaminated marshy areas, leaving the poor behind.[1009]

7.5 Conclusion

This chapter has demonstrated the varied roles which dispensaries played in public health developments during the late eighteenth and early nineteenth centuries. This included, in the case of Edinburgh and Newcastle dispensary medical staff, the authorship of studies detailing the need for greater intervention by civic authorities in areas such as sanitation and housing. This demonstrates the keenness on the part of the dispensary's staff to provide medical relief beyond the prescription of medications and to include disease prevention, as well as treatment, in the remit of their work. The Kelso dispensary, by contrast, as touched upon in chapter two, focused primarily upon the treatment of individual ailments. Although its remit was broadened somewhat to include first inoculation and then vaccination, it does not appear to have stretched to wider attempts to influence public health developments. The additional aims of the Edinburgh and Newcastle dispensaries, including to influence public policy and to educate their patients regarding the importance of hygiene, were absent from the goals of the Kelso dispensary. Without the strong guiding hand of a medical practitioner keen to advance their career and to use the dispensary for wider medical goals, as was the case with Duncan and Clark, the Kelso dispensary maintained its focus on its primary operational purpose.

This chapter, however, has also demonstrated the limitations in the ability of dispensaries, as institutions, to influence local public health-related provisions. While both Duncan and Clark's dispensary work may have provided insight and impetus regarding the need for substantial improvements to local environmental conditions, it was beyond the confines of those institutions where the work of those two men had its greatest impact. In the case of Duncan, his professorship at the University of Edinburgh provided him with a

[1008] Ibid., pp.312-313.
[1009] Dobson, *Contours of Death and Disease in Early Modern England*, p.26.

platform to disseminate his ideas on the subject, while many of Clark's undertakings in this regard followed his election to a post at the Newcastle infirmary. Moreover, the relationship between these physicians' dispensary work and these broader activities is open to question. As noted previously, historians such as Rosen and Porter have argued that the catalyst for such initiatives was the exposure which dispensary physicians had to the inadequate living conditions of their patients when visiting them in their own homes. It is notable, however, that one of the most vocal supporters of the public health movement in the late eighteenth century was Andrew Duncan, a man who appears to have placed little weight on the importance of carrying out such home visits. Rather than being inspired as a result of their dispensary activities, therefore, it seems likely that a pre-existing interest in matters of public health provided the impetus for the establishment of these charitable dispensaries.

Conclusion

It has been the aim of this project to examine the role of dispensaries in the provision of medical relief in the late eighteenth and early nineteenth centuries. Specifically, this project has explored the origins, the operational models, and the patients of the Edinburgh, Kelso, and Newcastle dispensaries. In doing so, it has contributed significantly to the body of historical scholarship on medicine in Scotland and the north east of England and provided insight into an area of medical practice which has hitherto been little examined. Dispensaries were essential, not only to the medical men who established their careers in their service, but also to the large number of patients who were treated by them. By visiting patients in their homes rather than removing them into institutional care, dispensaries enabled patients to continue their employment and maintain access to their family and community support systems. Studying this aspect of medical practice, therefore, allows for a distinctly different understanding of the lives and working conditions of the sick poor than the study of residential institutions such as infirmaries or workhouses. This project, by comparing the dispensary model of treatment to the approaches adopted by those other institutions, has demonstrated the impact which these various operational models had on the patient's experience of medical treatment. In doing so, it challenges the emphasis placed by historians on the central role of residential institutions in the treatment of the sick poor.

Alannah Tomkins has noted the challenges which are inherent in attempting to locate the perspective of the poor in historical records for this period.[1010] Although this study, by necessity, accesses the patient's voice through the intermediary of the medical practitioner, their voices can still be identified and this study has significantly enhanced understanding of how charitable patients experienced the treatment which they received. It also provides new insights into the living circumstances of the poor by focusing upon complaints which were commonly viewed as prevalent, chronic, and non-fatal, including intestinal worms, urinary complaints, and indigestion. This is an area of study which has frequently been neglected in the history of medicine with the focus more often placed on

[1010] Alannah Tomkins, ' 'I mak Bould to Wrigt': First-Person Narratives in the History of Poverty in England, c.1750–1900', *History Compass*, 9:5 (2011), pp.365–373.

more severe and frequently fatal conditions such as syphilis and consumption. Historians, including Ian Miller and Jonathan Andrews, have emphasised the need for greater scholarship on less critical but more often long term conditions.[1011] By considering the underlying conditions which the sick poor experienced this study highlights how illness did not necessarily take the form of an exceptional or critical event and was more often a mundane and everyday ailment which an individual suffered from for years, even decades.

It is, however, the comparative element of this study that lends the strongest contribution to historical knowledge and research. Edinburgh, Kelso, and Newcastle provided three very different contexts for the development of dispensary activities during the late eighteenth and early nineteenth centuries. Newcastle, as an industrialising city whose population had almost doubled in the preceding century, had a fluctuating economy, with much employment dependent on the stability of the coal trade. This resulted in a significant geographical imbalance within the city, where recent migrants and the most impoverished predominantly settled close to the river. Those who migrated to Newcastle seeking work originated primarily from across the north east of England and Scotland. These included Scottish border towns such as Kelso, which correspondingly experienced a significant exodus of working-age individuals during the period, a factor further compounded by an increase in elderly residents in the town, individuals who were no longer able to find work in smaller villages or crofts in surrounding districts. Edinburgh, while not impacted by economic migration to quite the extent of either Newcastle or Kelso, experienced challenges of its own. The economic impact of increasing secessions from the Church of Scotland was mitigated somewhat by the decision of Edinburgh's Town Council to centralise the majority of the city's poor relief funding under one body rather than leave it to individual parishes to administer. The creation of Edinburgh's New Town in the late eighteenth century, however, as with Newcastle, served to increasingly separate the wealthy and educated elite from the city's poor.

These economic and social factors influenced local approaches to medical practice. Kelso, as perhaps befitted its relatively small size, had no workhouse, no medical professionals in the employ of local poor relief authorities, and no infirmary. Edinburgh, by

[1011] Ian Miller, *A Modern History of the Stomach: Gastric Illness, Medicine and British Society, 1800-1950* (Abingdon and New York, 2016), p.5; Andrews, 'History of Medicine: Health, Medicine and Disease in the Eighteenth Century', p.507.

contrast, had a distinctly structured approach to medical practice, with two medical colleges, those of physicians and surgeons, a large infirmary which was partially managed by the local university's medical faculty, and medical provision within the city's workhouses. While Newcastle was home to both an infirmary and workhouses, the former was small by contrast to the infirmary in Edinburgh and that city's workhouse provision significantly more limited. Accessing the services provided by such infirmaries and poor relief systems necessitated contending with a wide array of rules and conditions. In chapter one, it has been shown how, under infirmary provision, the sick still had to convince the admissions staff that their condition was suitable, acute rather than chronic in nature, and not on the list of banned medical categories. In addition, this thesis has argued that an infirmary based in a particular city should not be assumed to have been entirely a local resource for local people, with both the Edinburgh and Newcastle infirmaries accepting patients from locations which were far beyond the confines of the cities in which they were based.

This thesis has also explored differences between infirmary approaches to funding during the late eighteenth and early nineteenth centuries. Although infirmaries have commonly been characterised by historians as providing treatment free of charge, the Edinburgh infirmary provides an exception to this, with many of its wards only being accessible to particular funded occupational groups such as military and navy personnel. This was largely due to the Edinburgh infirmary's rejection of the subscription model of funding which many English infirmaries, including that in Newcastle, adopted from their foundation. The Edinburgh infirmary did not establish a similar system until the final years of the eighteenth century. The outcomes of this approach were not only financial; they impacted on the Edinburgh infirmary's treatment of its patients.

Amanda Berry's study of eighteenth-century hospital patronage has emphasised the central role which financial supporters played in formulating the regulations of those institutions.[1012] In the case of the Edinburgh infirmary, freedom from this subscription model of funding allowed its medical staff to make decisions on admission criteria independently of the influence of financial supporters. The Newcastle infirmary, like many of its English counterparts, was managed in large part by its benefactors and, as a result, their admission regulations were based on moral as well as medical criteria. The Edinburgh

[1012] Berry, ' "Balancing the Books" Funding Provincial Hospitals in Eighteenth-Century England', pp.1-30.

infirmary's management structure, by contrast, enabled it to establish a lying-in ward for pregnant women and to allow admission of groups such as venereal patients. In addition, unlike its English counterparts, the Edinburgh infirmary accepted patient suffering from contagious diseases, including smallpox and typhus. The Edinburgh infirmary, however, applied restrictions of its own, for, from 1754, it only accepted inpatients and did not offer an outpatient service. Both the Edinburgh and Newcastle infirmaries further restricted access to their services in the late eighteenth and early nineteenth centuries, with the Edinburgh infirmary refusing access to new patients as a result of lack of funds, while the Newcastle infirmary did likewise as a result of a lack of available ward beds.

In addition, this study has emphasised how poor relief systems attempted to determine the right of the poor to support by categorising them by a range of criteria in an attempt to identify whether they were deserving or undeserving of relief. It is also contended that the growth of workhouse provision in the later eighteenth century in both Edinburgh and Newcastle demonstrates a determined attempt to ensure that only those who were in the most desperate need were provided access to relief. Individuals who were recipients of relief were, unsurprisingly, more cautious about such institutions and historians have noted that, even amongst those individuals who met the stringent admission criteria of the charity workhouses, there was an unwillingness on the part of many to make use of their services unless they were in the most desperate of circumstances.[1013] However, while medical treatment within these workhouses was limited, in some cases non-existent, the provision of food and shelter for those who were sick provided a survival mechanism beyond merely the prescription of medicaments.

This research has shown that the establishment of the Edinburgh and Newcastle dispensaries allowed access to medical provision for individuals whose treatment had been restricted by the pre-existing infirmaries and workhouses in those cities. In the case of Kelso, the establishment of the dispensary there allowed access by the local population to a charitable medical institution for the first time. In chapter two it was shown how dispensaries, by contrast to infirmaries, required little funding or public support to enable their establishment. There was no need for large premises or administrative staff. Their founders could rely on their circle of friends to contribute the minimal funds needed and to

[1013] For a more detailed discussion on this subject see Paul A. Fideler, *Social Welfare in Pre-Industrial England: The Old Poor Law Tradition* (Basingstoke, 2006), pp.148-164.

provide unpaid medical support. A dispensary's finances, staffing, and public profile could then be built up in the decades following its foundation. The small scale of the early iterations of the Edinburgh and Newcastle dispensaries demonstrates how significant public support was not necessary to initiate such an endeavour, just the will of a single determined individual. The dispensary could then demonstrate its value through its increasing admissions, the wide range of services it offered, and its positive patient outcomes, all of which would be promoted via the public press.

The Edinburgh, Kelso, and Newcastle dispensaries were part of a wider dispensary movement, beginning in the 1770s, which saw the development of similar institutions in towns and cities across Britain. These were argued by contemporaries to be both cheaper than their infirmary counterparts and to be a more effective method of preventing the undeserving poor from accessing medical relief as they commonly did not offer food or shelter to their patients. Within the broader context of this dispensary movement the institutions under study in this thesis have been shown to possess certain distinctive traits. It has been a common feature of the existing historiography to note that dispensaries were more likely than infirmaries to be founded by medical professionals and, in addition, many of these studies have emphasised the outsider status of these founding physicians. These individuals were not commonly part of the established medical elite and their dispensary roles could be used to enhance their professional status by providing content for their medical publications and allowing access to more elevated positions within infirmaries, academia, and prestigious medical clubs and committees. The careers of Andrew Duncan and John Clark, the founders, respectively, of the Edinburgh and Newcastle dispensaries, largely follow this established model.

By applying a comparative approach to the study of dispensary services, however, this thesis has demonstrated variations from the existing historiographical approach. The Kelso dispensary was founded, although with the assistance of local medical professionals, primarily as a result of undertakings by members of the local landed gentry, particularly Elizabeth Baillie. Existing research which has been carried out by historians on dispensaries during this period has focused particularly on those founded by prominent medical practitioners, including John Coakley Lettsom, in the context of his undertakings at the

General Dispensary in London, and Joshua Dixon in Whitehaven.[1014] This thesis questions the emphasis which, as a result, is placed upon the most high-profile of eighteenth-century dispensary practices, an approach which has resulted in a somewhat monolithic interpretation of their structure and undertakings. Further research remains to be done in order to broaden understanding of the range of dispensary services which was available during the late eighteenth and early nineteenth centuries. Understanding of the role of these institutions would be advanced significantly by focusing in more detail on the less prominent dispensaries which were established in smaller towns and rural districts during this period.

This thesis has argued that these differences in dispensary origins impacted on their finances, their management models, and their admissions policies. The Kelso dispensary, as an institution which was backed by local authorities and gentry from the outset, received support and encouragement from the surrounding community. Both the Edinburgh and Newcastle dispensaries, by contrast, faced considerable local opposition, including from the infirmaries in their respective cities. The Edinburgh dispensary's foundation proved particularly contentious because of its role, unique amongst eighteenth-century dispensaries, in the provision of clinical teaching. This educational aspect to the Edinburgh dispensary's work also influenced its admissions policies which, from its foundation, were not restricted to individuals with recommendations, but rather were open to anyone who put themselves forward for treatment. The need to provide an array of medical complaints for teaching purposes is likely to have played a part in the adoption of this approach. Likewise, the Edinburgh dispensary's initial decision not to provide a home visiting service was influenced by the need for patients to be used for teaching purposes. The Edinburgh dispensary's regulations were revised over subsequent years, however, and a somewhat unstructured system of home visiting was later introduced.

Revisions were also made to the treatment model of the Newcastle dispensary in the decades following its foundation. At that dispensary, from 1790, individuals without recommendations began to be admitted. This thesis has demonstrated how this development had a significant impact on the work of the dispensary, not only allowing a greater number of patients to be treated, but also expanding access to a broader range of

[1014] James Johnston Abraham, *Lettsom: His Life, Times, Friends and Descendants* (London, 1933); Sydney, *Bleeding, Blisters and Opium: Joshua Dixon and the Whitehaven Dispensary.*

individuals. The historiography of eighteenth-century charitable medical care, with its focus predominantly on infirmary provision, has identified in those institutions an emphasis on the admission of working age males. This study, by exploring the distinctive nature of dispensary treatment, provides significant contrast with these existing works. A focus by infirmaries on the importance of the male breadwinner who provided for his family often served to marginalise women and prejudice against them in the selection of patients for admission to these institutions. In her study of the Bath infirmary, Anne Borsay argued that this broader societal perception of women's work and women's roles as being less crucial than those of men restricted women from gaining access to that institution.[1015] Indeed, male patients were not only more likely than their female counterparts to have an employer to sponsor them, they were also more frequently recommended for infirmary admission by other sources, such as those responsible for providing parish poor relief.[1016] Although dispensaries did not fail to mention the restoration of the sick to usefulness, as well as to health, the importance of providing assistance to families, to treating women and children alongside men, was more often clearly identified.[1017] Broader societal perceptions of the role of women were, to a certain extent, laid aside, with priority placed instead on the medical requirements of the local community.

As a result, as this research has demonstrated, the Edinburgh, Kelso, and Newcastle dispensaries admitted a significantly higher proportion of women than their infirmary counterparts. This was not entirely the result of their stated admissions policies; dispensary outpatient facilities had the additional advantage of allowing patients to continue working and caring for their families whilst undergoing treatment. The picture this thesis has illustrated in relation to age, however, is more mixed than that regarding gender, with admission rates of children and the elderly varying considerably between dispensaries. Differing local circumstances are likely to have played a role in this, including Kelso being home to a disproportionate number of aged individuals. It is also relevant to note, however, the impact of certain limitations which were inherent in the dispensary model of medical provision. Historians, including Jeremy Boulton and Leonard Schwarz, have demonstrated

[1015] Borsay, *Medicine and Charity in Georgian Bath*, p.229.
[1016] For a more detailed study of this phenomenon in the context of an English town, see Tomkins, 'Paupers and the Infirmary in Mid-Eighteenth-Century Shrewsbury', pp.222-223.
[1017] Anon., *An Account of the Newcastle Dispensary for the Relief of the Poor*, pp.5-7.

the reliance of significant portions of the elderly on both out relief and workhouse provision.[1018] Dispensaries, by contrast, may have provided a source of medical treatment for the aged sick but, unlike poor relief systems, they did not provide accommodation or food. Particularly for the elderly, therefore, the inability of dispensaries to provide the additional resources needed beyond the purely medical may have discounted them as a feasible option.

The greater freedoms, by comparison to their infirmary counterparts, which dispensaries experienced regarding patient admissions stretched beyond factors such as gender and age to include the medical conditions which they treated. This study has emphasised the need for caution when making connections between dispensary admission rates of certain conditions and the experiences of the sick in these localities, for the relationship between dispensaries and disease during the eighteenth century was a complex one. Disease terminology was not rigid and could be applied differently over time, in different locations, and by different practitioners within a single institution. This variation between scribes as to the application of these terms can create apparent changes over time when carrying out statistical analysis, without necessarily demonstrating changes in the patient's lived experiences of illness. Clerks and physicians could, and did, make mistakes, fail to fully understand the information which the sick individual was providing to them or, in some cases, even intentionally distort their records. In addition, when considering the records of the dispensaries it must be borne in mind that they do not provide an unbiased source, with the experiences of the sick poor mediated through the mouthpiece of the individuals who provided for them.

Furthermore, variations in the surviving sources have made it challenging to conduct a balanced comparison of the Edinburgh, Kelso, and Newcastle dispensaries. It is for this reason that the statistical analysis within this thesis has been focused on the Kelso and Newcastle dispensaries, while a more narrative approach has been adopted in the study of the Edinburgh dispensary. With these caveats, however, the more descriptive nature of the Edinburgh dispensary's case notes provides considerable additional detail about the lives of the patients who were treated there, their occupations, living circumstances, and the supposed causes of their complaints. The distinctive format of the Edinburgh dispensary's

[1018] Boulton and Schwarz, 'The Comforts of a Private Fireside'?, pp.221-240.

records also provides potential avenues for future research, including the study of the domestic treatments adopted by dispensary patients.

Where medical self-help methods of the poor are examined by historians, these are often considered with the caveat that the sources which are cited, such as apothecary bills, tend to primarily concern the better off and it cannot be assumed that the poor followed the same approaches.[1019] While the gentry and professionals have left a wealth of records, from diaries and correspondence to household accounts to study and decipher, the lack of archival sources concerning the poor has often resulted in sparse analysis, beyond extrapolation from the approaches identified of the more well off. Self-help remedies, however, can be traced through the dispensary records themselves, in which patients' use of home-made recipes, their purchasing of treatments from healers and apothecaries as well as folk traditions recommended by kin are detailed.[1020] Rather than attempting to extrapolate from previously studied resources such as recipe books and printed advertising and their use by certain demographics of society, records such as those of the Edinburgh dispensary provide evidence of self-help methods which are assuredly those adopted by individuals who accessed charitable medical relief.

The recording of such contextual information was a key aspect of the Edinburgh dispensary's approach to diagnosis and treatment. It was demonstrated in chapter four how the verbal examination of patients, including recording their opinions as to the cause of their complaint and how effective they perceived their treatments to be, remained an important component of the Edinburgh dispensary's treatment model into the nineteenth century. Previously, writers such as Nicholas Jewson, Guenter Risse, and Mary Fissell have argued that a shift took place from verbal to physical methods of examination with the establishment of charitable medical institutions. These studies, which based their findings primarily on infirmaries, stand in contrast to the research detailed in this thesis.

Dispensaries continued to emphasise the importance of verbal systems of examination due, in part, to the difficulty in witnessing all of a patient's symptoms when

[1019] For examples of studies where the primary focus of the work is the sick poor, but where consideration of self-help methods focuses particularly on sources relating to the more wealthy, see Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol*, pp.16-73; Marland, *Medicine and Society in Wakefield and Huddersfield*, pp.214-218.

[1020] For a more detailed discussion of the variation in definitions used in the study of medical self-help, see Stobart, 'The Making of Domestic Medicine', pp.6-10.

treating them under an outpatient system. This research argues for a similar rationale to the continued emphasis made by the Edinburgh and Newcastle dispensaries in the importance of the supply of medicaments. While Risse and Fissell have argued that infirmaries became increasingly reliant on physical methods of treatment such as bleeding and blistering, this study has found that the dispensaries focused rather on medication. Reasons cited by dispensary physicians, including Duncan, emphasise the difficulty of ensuring sufficiently regular attendance to carry out physical methods of treatment.

Furthermore, it is argued that these factors which made dispensaries less bureaucratic than their infirmary counterparts also made them more able to readily adapt to immediate needs within their communities. Chapters three, five, and seven consider the form which these adaptations took, including the provision of smallpox vaccination, the Newcastle dispensary's activities relating to local occupational health hazards such as drowning and suffocation in coal mines, and the rapid responses of dispensaries to local outbreaks of contagious diseases. Duncan and Clark particularly showed themselves willing to respond to broader societal issues such as changing urban environments, food shortages, and sanitation concerns.

While this research has shown that their smaller size and more streamlined management structures meant that dispensaries were more agile than infirmaries, more readily able to respond to changes in local circumstances, it has also questioned the extent to which these developments were entirely based on local needs. Bronwyn Croxson has argued that 'there is no direct relationship between the needs of the poor and the supply of charity'.[1021] This can be witnessed in Edinburgh and Newcastle where, in both cities, the desire for career advancement on the part of the individual physician played as great a role in the decision to establish a dispensary as the particular needs of the sick poor. The notion of the 'outsider' physician is particularly pronounced in both these cases and, while studies which focus on individual high-profile practitioners have increasingly been critiqued by historians, in these instances the motives and undertakings of the physicians Duncan and Clark were central to determining the approaches which their dispensaries adopted towards the admission and treatment of patients.

[1021] Croxson, 'The Public and Private Faces of Eighteenth-Century London Dispensary Charity', p.149.

The approaches adopted by these dispensary physicians in the late eighteenth century were embedded and further developed in subsequent decades. Visiting patients in their own homes provided dispensary physicians with increased understanding of, and ability to elucidate in print, deficiencies in the living conditions of the poor. This became an increasingly central component of dispensary practice over the course of the nineteenth century and served to distinguish these institutions more clearly from their contemporaries. While the staff of residential institutions such as infirmaries and workhouses continued to look inwards towards the patients who were housed within their walls, dispensary physicians looked outwards, viewing their patients within the context of their communities. As understanding of the principles of contagion grew, overcrowding, ineffective sanitation, and inadequate diets were increasingly identified as being within the purview of dispensary physicians. As a result, when, in the mid nineteenth century, a range of government reports were commissioned to review the current state of sanitation and housing across Britain, dispensary physicians, and the studies which they produced, proved to be key sources of information.[1022]

The city authorities of Newcastle were highlighted in several of these government inquiries as having failed in a particularly stark manner to take sufficient action in relation to sanitation concerns.[1023] Overcrowding was also a considerable issue within the city for most of the nineteenth century. The Newcastle dispensary noted in one of its annual reports that this problem was further exacerbated by a railway development project which had necessitated the demolishing of large sections of the city's residential properties.[1024] The role of the dispensary, however, was far broader than simply elucidating concerns such as these in print. During a major cholera outbreak in Newcastle in 1853 the dispensary was kept open all day and night in order to treat as many patients as possible.[1025] Additional staff were taken on and carriages provided to enable them to visit patients across a wide

[1022] Anon*., Poor Law Inquiry (Scotland). Appendix Part 1. Containing Minutes of Evidence Taken at Edinburgh, Glasgow, Greenock, Paisley, Ayr, and Kilmarnock* (Edinburgh, 1844), pp.142-143; Anon., *Poor Law Inquiry (Scotland). Appendix Part 3. Containing Minutes of Evidence Taken in the Synods of Angus and Mearns, Perth and Stirling, Fife, Glasgow and Ayr, Galloway, Dumfries, Merse and Teviotdale, Lothian and Tweeddale* (Edinburgh, 1844), pp.689-692.

[1023] Anon., *Report of the Commissioners Appointed to Inquire into the Causes Which Have Led To, Or Have Aggravated the Late Outbreak of Cholera in the Towns of Newcastle-Upon-Type, Gateshead, and Tynemouth* (London, 1854), pp.1-475; Anon., *First Report of the Sanitary Commission, with the Minutes of Evidence up to 5th August 1869* (London, 1870) p.4, pp.156-171.

[1024] Anon., *Annual Report of the Newcastle Dispensary* (Newcastle, 1847), p.6.

[1025] Anon., *Annual Report of the Newcastle Dispensary* (Newcastle, 1854), p.6.

geographical area.[1026] During this outbreak the dispensary, on the request of local civic authorities, took entire charge of the treatment of the infected in two of the hardest hit districts of the city.[1027]

The approach of Edinburgh's dispensaries towards public health concerns provides an even more clear example of the expanding remits of such institutions. William Pulteney Alison and the New Town dispensary which he helped to establish became central to the nineteenth-century public health movement in Scotland. The Scottish model of provision, initiated by Duncan's work on public health in the previous century, identified more closely with its wide-reaching European equivalents than its English counterpart. While English reformers such as Edwin Chadwick focused primarily on sanitation as the cause of ill health, Alison emphasised the role of poverty and the need to address deficiencies in poor relief provision.[1028] Under the guiding hand of individuals such as Alison the remit of medical practitioners broadened far beyond the treatment of individual sick patients. Medicine increasingly became seen as encompassing all that did, or could, impact on a person's health and wellbeing. As a result, the eighteenth-century focus on individual initiative and charitable giving gave way to an emphasis on standardising approaches, legislative requirements, and the need for a centralised system of public health management.

The Edinburgh, Kelso, and Newcastle dispensaries continued to play an important role in these wider developments into the twentieth century. That these dispensaries survived, and flourished, for such an extensive period is testament to the impact of their work. This value was further recognised when the National Health Service Act came into effect in 1948 and the Kelso dispensary was incorporated into this new body.[1029] In the same year the Edinburgh dispensary was subsumed into the University of Edinburgh and became the centre of a new General Practice Teaching Unit.[1030] In this form, it continued the activities of both educating medical students and the treatment of patients. The Newcastle dispensary, however, suffered a different fate. Although it was initially considered for

[1026] Ibid.
[1027] Ibid., p.7.
[1028] William Pulteney Alison, *Observations on the Management of the Poor in Scotland, and its Effects on the Health of the Great Towns* (London, 1840); William Pulteney Alison, *Illustrations of the Practical Operation of the Scottish System of Management of the Poor* (1840).
[1029] *Anon., Annual Report of the Newcastle Dispensary* (Newcastle, 1948), p.3.
[1030] Donald M. Thomson, 'General Practice and the Edinburgh Medical School: 200 Years of Teaching, Care and Research', *Journal of the Royal College of General Practitioners*, 34 (1984), p.11.

incorporation into the National Health Service it was, for reasons which remain unclear, ultimately not accepted for inclusion.[1031] The dispensary's managers decided to continue its activities as an independent body, but to change its model of operation to focus entirely on the treatment of arthritic complaints.[1032] In the decades that followed the financial deficit of that institution increased as its subscriptions declined and it was forced to regularly sell off investments in order to realise the funds needed to continue operating.[1033] Finally, after struggling on for almost thirty more years, the Newcastle dispensary closed in 1976.[1034]

To conclude, this study has explored the roles of the Edinburgh, Kelso, and Newcastle dispensaries in the provision of charitable medical relief between 1776 and 1810 by considering their management models and their approaches to patient treatment. Differences between the demographics of patients who were admitted to these institutions and those provided for within infirmaries and poor relief models resulted from a range of factors. In some cases these were encouraged by the dispensaries with the intention of opening up access to groups who had been excluded from treatment at other charitable institutions. In other instances they were coincidental, the result of adopting an outpatient, rather than inpatient, model of treatment. While there were variations in existing local resources for the sick poor, particularly in Edinburgh where the local infirmary had unusually open admission regulations, the limited number of available beds still significantly restricted access to such institutions. Dispensary outpatient models of treatment, by contrast, were more easily able to expand their provision in order to meet local demand. Variations between dispensaries, however, provides a note of caution in overemphasising the evolving nature of dispensary treatment. A dispensary situated in a large city and staffed by enthusiastic young medical professionals was likely to engage with new medical developments and theories. Not all dispensary physicians, however, saw their role as being to innovate and influence medical theory and practice in this manner. Others, such as the Kelso dispensary, focused on the primary goal of providing a medical service to their local community.

[1031] Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1947), pp.3-4.
[1032] Anon., *Newcastle Dispensary Annual Report* (Newcastle, 1949), p.3.
[1033] *Newcastle Dispensary Committee Minutes*, 26 March 1957, 26 January 1960, 7 July 1971, 25 June 1973, 22 December 1975 (TWA, HO.ND/1).
[1034] Ibid., 28 June 1976.

Appendix

Medical condition categories

Source: Guenter Risse[1035]

1. Circulatory disorders

Anasarca	Aneurysm	Ascites
Congestion	Disease of the heart	Dropsy
Epistaxis	Haematoma	Haemorrhage
Haemorrhoids	Hemophagia	Hydrocephalus
Hydrothorax	Mors senilis	Necrosis
Palpitation	Piles	Plethora
Varicose leg		

2. Diseases of the digestive system

Abdominal obstruction	Apepsia	Bilious complaint
Bowel complaint	Cardialgia	Catharsis
Cholera	Colic	Colica pictonum
Constipation	Costiveness	Crampish pains
Diarrhoea	Difficulty swallowing	Diseased liver
Dolor ventriculi	Dysentery	Dyspepsia

[1035] Risse, 'Hospital History: New Sources and Methods', pp.180-181. Risse's disease categories have been adapted to include diseases detailed in *Practical Observations in Medicine by Andrew Duncan*, 1776-1790 (DEP/DUA/1/11-47); *Kelso Dispensary Patient Registers*, 1780-1805 (HH71/7-8 and HH71/43); Anon., *Newcastle Dispensary Annual Reports* (1780-1810). The conditions which are included here which are additions to Risse's original classification are detailed below. Circulatory disorders: disease of the heart, epistaxis, haematoma, haemorrhage, piles, hemophagia, mors senillis, necrosis, varicose leg. Diseases of the digestive system: Abdominal obstruction, apepsia, cardialgia, catharsis, constipation, dolor ventriculi, excrescence in ano, flatulence, gallstones, gastralgia, gastrodynia, gripes, haematemesis, heartburn, indigestion, laxation, lientery, melaena, prolapsed anus, purging, pyrosis, tympanites, visceral obstruction, vomiting, vermes. Diseases of the skin: abscess on skin, boil, carbuncle, crusta lacteal, cutaneous eruption, erythema, frost bite, itchy, macula maternae, paronychia, prurigo senilis, pruritus, scabies, sinous in back, sore on back / thigh / foot / face, St Anthony's Fire, suppuration, tinea capitis, ulcer on skin, verruca, wen, whitloe. Eye problems: abscess in eye, adhesion of palpebral, albugo, cataracts, dysopia, episcleritis, exopthalmia, fistula lachrymalis, gutta serena, leucoma, scrofulous ophthalmia, staphyloma. Genito-urinary diseases: abortion, affection of kidney, childbed fever, chlorosis, cystorrhea, dysmenorrhea, female complaints, fluor albus, flooding, graviditas, hematuria, hydrocele, miscarriage, obstructed menses, painful testicles, paraphimosis, profluvia lochia, profuse menses, prolapsed uterus, puerperal fever, renal affection, strangury, ulcer in bladder, venereal disease. Infectious and epidemic diseases: anthrax, chicken pox, chin cough, erysipelatous fever, febrile complaint, influenza, rush fever, synochus, vesicatory fever. Musculo-skeletal disorders: ankylosis, aphalagia, carious bones, club foot, contracted leg, coxalgia, crooked spine, exfoliations from the tibia, fistula in knee, ganglion, gout, inflamed ankle / arm / leg, lameness, lumbar abscess, rigidity of bicep muscle, spina ventosa, trismus, white swelling. Neurological-mental diseases: apoplexy, bulimia, cephalalgia, cephalea, convulsions, delirium, fatigue, fatuitas, hemicrania, hemiparesis, incubus, insanity, languor, nervous affection, nervous headache, noctambulation, stroke, St Vitus's Dance. Respiratory ailments: asphyxia, bronchocele, coalition of the nostrils, consumption, cough, croup, disorder of the breast, emphysema, empyema, fungus in the nose, hiccup, imperfect nostrils, ozaena, peripneumonia, quinsy, singultus, tussis senilis. Miscellaneous medical conditions: chronic, complication, effusion, flying pains, valetudo conquassata, weakness.

Enteritis	Excrescence in ano	Flatulence
Gallstones	Gastralgia	Gastrodynia
Gripes	Haematemesis	Heartburn
Hepatitis	Icterus	Ileus
Indigestion	Inflamed liver	Jaundice
Laxation	Lientery	Melaena
Mortification of the bowels	Obstinate flux	Physconia of the bowels
Prolapsed anus	Purging	Pyrosis
Spitting of blood	Stomach complaint	Stomach spasm
Tympanites	Vermes	Visceral obstruction
Vomiting	Worms	

3. Diseases of the skin

Abscess on skin	Boil	Carbuncle
Chilblain	Crusta lacteal	Cutaneous eruption
Eruption	Erysipelas	Erythema
Excrescence	Frost bite	Herpes
Impetigo	Itch	Itchy
Lepra	Macula maternae	Paronychia
Prurigo senilis	Pruritus	Psora
Rose (the)	Scabies	Scorbutic eruption
Scurvy	Sinous in back	Sore on back /thigh / foot / face
St Anthony's fire	Suppuration	Tinea capitis
Ulcer on skin	Urticaria	Verruca
Wen	Whitehead	Whitlow

4. Eye problems

Abscess in eye	Adhesion of palpebral	Albugo
Amaurosis	Caligo	Cataracts
Dysopia	Episcleritis	Exophthalmia
Fistula lachrymalis	Gutta serena	Leucoma
Opacity of cornea	Ophthalmia	Scrofulous ophthalmia

5. Genito-urinary diseases

Abortion	Affection of kidney	Amenorrhoea
Anuria	Bladder disease	Calculus
Childbed fever	Chlorosis	Cystorrhea
Diabetes	Dysmenorrhea	Dysuria
Enuresis	Female complaints	Flooding
Fluor albus	Gonorrhoea	Gravel
Graviditas	Hematuria	Hydrocele
Incontinence of urine	Inflammation of bladder / kidney	Ischuria
Leucorrhoea	Lues venerea	Menorrhagia
Miscarriage	Nephritis	Obstructed menses
Painful testicles / bladder	Paraphimosis	Phimosis
Profluvia lochia	Profuse menses	Prolapsed uterus

Puerperal fever	Renal affection	Sibbens
Stone	Strangury	Suppression of urine
Swollen testicles	Syphilis	Ulcer in bladder
Urinary complaint	Uterine disease	Venereal disease

6. Infectious and epidemic diseases

Ague	Anthrax	Chicken pox
Chin cough	Continued fever	Erysipelatous fever
Febrile complaint	Fever	Hectic fever
Influenza	Intermittent fever	Measles
Mumps	Pertussis	Putrid fever
Rush fever	Scarlatina	Scarlet fever
Smallpox	Synochus	Typhus
Vesicatory fever	Whooping cough	Yellow fever

7. Musculo-skeletal disorders

Ankylosis	Aphalangia	Back pain
Carious bones	Club foot	Contracted leg
Coxalgia	Crooked spine	Diseased ankle / arm / finger / knee / leg / toe
Exfoliations from the tibia	Fistula in knee	Ganglion
Gout	Inflamed ankle / arm / leg	Ischias
Lameness	Lumbago	Lumbar abscess
Sore arm / leg / knee	Rheumatism	Rickets
Rigidity of bicep muscle	Sciatica	Spina ventosa
Stiff arm / neck / leg / joint	Swollen wrist knee / hand	Tetanus
Trismus	Weak arm	White swelling

8. Neurological-mental diseases

Apoplexy	Bulimia	Cephalalgia
Cephalea	Chorea	Concussion
Convulsions	Deafness	Delirium
Epilepsy	Fatigue	Fatuitas
Headache	Head complaint	Hemicrania
Hemiparesis	Hemiplegia	Hypochondriasis
Hysteria	Incubus	Insanity
Languor	Lethargy	Mania
Melancholy	Nervous affection	Nervous headache
Noctambulation	Nostalgia	Palsy
Paralysis	Phrenitis	Senility
Stroke	St Vitus's Dance	Vertigo

9. Respiratory ailments

Angina	Asphyxia	Asthma
Breast complaint	Breast pain	Bronchocele

Catarrh	Coalition of the nostrils	Cold
Consumption	Cough	Croup
Cynanche	Disorder of the breast	Dyspnoea
Emphysema	Empyema	Fungus in nose
Haemoptysis	Hiccup	Imperfect nostrils
Inflamed breast	Ozaena	Pain in breast / side
Peripneumonia	Phthisis	Pleurisy
Pneumonia	Pulmonary complaint	Pulmonia
Quinsy	Singultus	Sore throat
Tussis senilis		

10. Miscellaneous medical conditions

Anomalous complaint	Chronic	Complication
Convalescence	Debility	Effusion
Feigned complaint	Flying pains	Pain
Valetudo conquassata	Weakness	

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